MANAGED CARE TRACKING SYSTEM

SAMHSA

State Profiles on Public Sector Managed Behavioral Health Care and Other Reforms

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration

Produced for the
Substance Abuse and Mental Health Services Administration (SAMHSA)
JULY 31, 1998

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Acknowledgments

This guide was prepared by The Lewin Group, 9302 Lee Highway, Suite 500, Fairfax, VA 22031, (703) 218-5500, under the project direction of Gail K. Robinson, Ph.D. The Senior Advisor was Leslie Scallet, J.D., Vice President. Additional staff members were Gail Toff Bergman, Project Manager; Douglas Fountain, Senior Manager; Christina Hughes, Analyst; Sarah Crow, Research Assistant; Traci Tunkelrott, Associate; and Kathy Trzeciak, Staff Assistant.

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The project team would like to thank a number of individuals outside of the Lewin team who contributed to this report. In particular, we would acknowledge the directors of and staff from all Medicaid agencies in the 50 States and the District of Columbia, State Mental Health Authorities and State Alcohol and Drug Abuse Agencies for the countless hours they spent verifying the information on their programs, sending additional information, and participating in sometimes lengthy telephone conversations to answer specific questions about their programs. We would also like to thank the members of our Stakeholder Advisory Council and their organizations for helping us establish the infrastructure necessary to complete this task.

The Department of Health and Human Services (DHHS) has reviewed and approved policy-related information in this document but has not verified the accuracy of data or analysis presented in the document.

The opinions expressed in this document are the views of the authors and do not necessarily reflect the official position of the Substance Abuse and Mental Health Services Administration (SAMHSA), the Health Care Financing Administration (HCFA), or the U.S. Department of Health and Human Services.

DHHS Publication No. (SMA)99-3280

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I. Introduction and Methodology

The information in this report was collected for the Substance Abuse and Mental Health Services Administration (SAMHSA) Managed Care Tracking System from January through July 1998. It includes descriptions of public sector managed behavioral health care programs in the 50 States and the District of Columbia. The tracking system collects information and analysis on the impact of managed care on Medicaid behavioral health services and public mental health and substance abuse systems.[1]

Notable Findings

- A total of 97 managed care programs operating in 47 States include some form of mental health and/or substance abuse services. Forty-six of these programs are integrated health plans with some mental health and/or substance abuse benefits; 45 are programs specific to mental health and/or substance abuse and are not associated with physical health plans (i.e., stand-alone); 5 are carve-outs from physical health programs; and 3 are partial carve-out programs.[2]
- Fifty percent of the managed care programs that include mental health and/or substance abuse services use Medicaid waivers. The remainder are either voluntary Medicaid programs, do not restrict choice of Medicaid providers, or involve programs outside the purview of Medicaid.
- Ten States (Arizona, Colorado, Kentucky, Michigan, Montana, New Mexico, Pennsylvania, Tennessee, Utah, Washington) report that they no longer have mental health and/or substance abuse services under a fee-for-service system (except those provided to specific populations, e.g., American Indians, dual eligibles, and special needs children) or that they have very limited services remaining as fee-for-service.
- Most integrated managed care programs (76 percent, or 27 states), contract with private sector organizations as the managed care entity. Out of a total of 53 programs specific to mental health and/or substance abuse (i.e., stand-alone, carve-out, and partial carve-out), 30 programs in 26 States are managed by public sector agencies or public/private partnerships (57 percent).
- Private sector organizations (i.e., health maintenance organizations and managed care organizations) are responsible for most managed care programs that provide acute mental health and substance abuse services. Specialty long-term care mental health and substance abuse services are generally separated from acute care health plans (stand-alone, carve-out, partial carve-out) and managed by local government entities and networks of community providers in conjunction with commercial managed care vendors. Half of all States with carve-out or stand-alone arrangements contract with government agencies or public/private partnerships to manage the program.
- Most States place managed care entities at risk, even if that managed care entity is a public sector agency. Managed care entities continue to pay providers on a fee-for-service basis without transferring financial risk. When providers are also the managed care entity, however, they are paid on a capitated basis and are at risk.
- Managed care programs offer a broad array of mental health and substance abuse services. Most programs cover mental health inpatient and outpatient services; over three-quarters cover outpatient mental health and over half cover mental health rehabilitation and outpatient substance abuse services. Detoxification (acute, subacute, and ambulatory) services are covered by one-third of the programs, and an additional one-fourth cover Institution for Mental Diseases (IMD)[3] services and mental health and substance abuse residential services.

[1] Additional reports will be published. One provides a quantitative analysis of the qualitative information collected during 1997 under the prototype tracking system.

[2] These do not sum to 97 because two programs have both integrated and carve-out components.

[3] States have the option of covering services provided in IMDs for individuals under age 21 and over age 65, under their Medicaid Plans.

- Over one-third of the mental health specific programs cover residential, crisis, rehabilitation, and support services.
- Most programs that cover substance abuse services are either integrated with physical health plans or combined with mental health services in a behavioral health managed care program. Thus, two waiver programs cover substance abuse services exclusively (Iowa, Minnesota); one is a full carve-out from a physical health plan for substance abuse services exclusively (Missouri); five are internal substance-abuse-only managed care programs in State substance abuse agencies (i.e., non-Medicaid) (Florida, Idaho, Kansas, New York, Rhode Island); and one is a prior authorization program for Medicaid substance abuse services (South Carolina).
- Medicaid is the largest source of funding for managed care programs. Seventy-nine percent of all managed care programs reporting financing information include Medicaid funds; 36 percent of these fund their programs with Medicaid dollars exclusively. General revenues are the next largest source of funding (44 percent), followed by block grants (18 percent), county funds (12 percent), State Department of Mental Health allocations (6 percent), and State Department of Alcohol and Drug Abuse allocations (3 percent).
- Sixty percent of programs explicitly mention targeting Aid to Families with Dependent Children/ Temporary Assistance for Needy Families (AFDC/ TANF) recipients; over half target Supplemental Security Income recipients; and over a third cover expanded women and children populations.
- Forty-eight percent of States report special provisions for mental health or substance abuse in approved TANF Welfare-to-Work plans.
- Medicaid is the lead agency for 53 percent of the programs; therefore, mental health or substance abuse authorities either are the lead agency or share responsibility with Medicaid for 47 percent of the programs. Looking only at Medicaid plans, mental health and substance abuse authorities either are the lead agency or share responsibility with Medicaid for 31 percent of the programs.

Methodology

This is the first of three annual State profile reports on data in a number of areas, including the organization, financing, and administration of managed behavioral health care programs in the public sector (see Appendix A for a complete project description). The report is based on information synthesized from various sources and then corrected and verified by at least three agencies in each State, including the single State Medicaid agency and mental health and substance abuse authorities. Verification was received from every State and the District of Columbia.

State descriptions were prepared by using baseline information from 1996 and 1997 and then incorporating and synthesizing updated information from the following sources:

- Print and electronic information sources;
- Interviews with National, State, and local contacts from government, provider, manager, consumer and advocacy organizations; and
- Other tracking systems' reports and studies.

A template was developed to guide data collection. Information is more comprehensive for some States than for others because of the nature of the data collection method. The SAMHSA Tracking System will focus on closing these information gaps in years two and three of the tracking project.

Organization of the Report

The remainder of this report is divided into two sections: Section II, a summary of major findings and current trends, reviews major findings from the synthesis of the State profiles. Tables are included. Section III presents State profiles of managed behavioral health care in the public sector.

II. Summary of Major Findings

State Status Report

Managed care has a strong presence in public sector mental health and substance abuse program design. All but four States now implement some form of managed behavioral health care. Medicaid is the primary vehicle by which States create and fund managed behavioral health programs. Thirty-six States operate 46 Medicaid waivers, 8 States operate 12 voluntary Medicaid health maintenance organization (HMO) programs, and 26 States have implemented managed care programs in related State systems (e.g., public mental health, public substance abuse, corrections, and child welfare).

The organization, financing, and structure of the programs vary tremendously. Some are comprehensive, covering multiple populations across the State; some are limited to one county or region; and some are risk-based, while others rely on new administrative strategies to manage care.

Status of Medicaid Waiver Programs

A total of 46 Medicaid waivers (36 States) that include some form of behavioral health have been implemented or approved (see table 1). Nineteen States with approved or implemented waivers use Section 1115 and 27 use Section 1915(b) waivers. Five States have more than one 1915(b) waiver (California, Iowa, Michigan, Nebraska, Texas), and three States have a combination of both 1115 and 1915(b) waivers (Colorado, Kentucky, Minnesota). Additionally, three States have either an 1115 or a 1915(b) waiver pending (Arkansas, Louisiana, Wisconsin) to include some form of behavioral health.[4]

Approximately two-thirds of the 46 waivers include both mental health and substance abuse, while one-quarter cover mental health services and not substance abuse services.[5] Of the 1115 waivers implemented or approved, 18 include both mental health and substance abuse and 1 includes mental health services and not substance abuse services. To date, no 1115 waivers cover substance abuse service exclusively. Of the 1915(b) waivers implemented or approved, 15 cover both mental health and substance abuse services, 7 cover mental health without substance abuse, and 3 cover substance abuse services without mental health (California, Iowa, Minnesota).

The Balanced Budget Act of 1997 (P.L. 105-33) (BBA) dramatically expands the authority of State Medicaid agencies to provide covered health services through managed care organizations (MCOs). States no longer must seek a waiver to implement mandatory managed care, although they will still need a waiver to implement mandatory managed care for special needs children, individuals dually eligible for Medicare and Medicaid, and Native Americans. Currently, waivered programs that are specific to mental health and/or substance abuse services (i.e., stand-alone, carve-out) are defined in the States' waiver applications as prepaid health plans (PHPs), not as MCOs. By definition, these organizations hold limited-risk contracts because the benefit package for which they accept risk does not include all Medicaid covered services. At this time it is unclear how the provisions of the new law will affect behavioral health carve-out and stand-alone programs. The BBA requires States to permit individuals to choose from not fewer than two managed care *entities* (defined as MCOs or primary care case management organizations. However, the Health Care Financing Administration (HCFA) has not ruled on whether PHPs will be considered managed care entities. If PHPs are not covered under the BBA provisions, States planning to contract with a PHP for stand-alone or carve-out programs will still need a waiver, and beneficiaries may not be afforded a choice. Until a ruling is made, we will not be able to determine whether the new law slows enthusiasm for carve-out or stand-alone programs.

Status of Non-Medicaid Managed Behavioral Health Care Programs

Of the 47 States that have managed care activity, 26 States operate 32 non-Medicaid managed care programs (table 2). Ten non-Medicaid programs focus on mental health treatment. Six programs focus on substance abuse treatment. Ten cover both mental health and substance abuse treatment, or are more general programs that offer some treatment for behavioral health services.

Non-Medicaid programs vary considerably in administration, service array, and target populations.

[4] The number of States does not total 36 because some have multiple waivers.

[5] A waiver may include physical health care services in addition to mental health and/or substance abuse services.

TABLE 1. MEDICAID MANAGED CARE STATUS REPORT—JULY 31, 1998
(Waivers that include mental health and/or substance abuse)

State	Medicaid						
		Section 1115			Section 1915(b)		
	Program	Pending/ Planning	Approved	Implemented	Pending/ Planning	Approved	Implemented
Alabama	BAY			MH SA			
Alaska	N/A						
Arizona	AHCCCS			MH SA			
Arkansas	Benefit Arkansas				MH		
California	Medi-Cal Specialty Mental Health Services Consolidation						MH
	Two-Plan Model						SA
Colorado	Mental Health						MH
	Integrated Care and Financing Pilot Project			MH			
Connecticut	Connecticut Access						MH SA
Delaware	Diamond State Health Plan			MH SA			
District of Columbia	HSCSN			MH SA			
Florida	PMHP						MH
Georgia	N/A						
Hawaii	Hawaii QUEST			MH SA			
Idaho	N/A						
Illinois	N/A						
Indiana	N/A						
Iowa	MHAP						MH
	IMSACP						SA
Kansas	N/A						
Kentucky	Access					MH SA	
	Health Care Partnerships			MH SA			
Louisiana	Pilot				MH		
Maine	N/A						
Maryland	HealthChoice			MH SA			
Massachusetts	MassHealth			MH SA			
Michigan	Comprehensive Health Plan					MH	
	MSSP						MH SA
	MIFPI						MH SA
Minnesota	PMAP			MH SA			
	MSHO			MH SA			
	CCDTF						SA
Mississippi	N/A						
Missouri	Managed Care +						MH SA
Montana	MHAP						MH
Nebraska	Nebraska Health Connection MH/SA						MH SA
	NE Health Connection Medical/ Surgical Component integrated						MH SA
Nevada	N/A						
New Hampshire	N/A						
New Jersey	MCCD		MH SA				
New Mexico	SALUD!						MH SA

TABLE 1. MEDICAID MANAGED CARE STATUS REPORT—JULY 31, 1998 (CONTINUED)
(Waivers that include mental health and/or substance abuse)

State	Medicaid						
		Section 1115			Section 1915(b)		
	Program	Pending/ Planning	Approved	Implemented	Pending/ Planning	Approved	Implemented
New York	Partnership Plan			MH SA			
North Carolina	Carolina Alternatives						MH SA
North Dakota	NoDAC						MH SA
Ohio	OhioCare			MH SA			
Oklahoma	SoonerCare			MH SA			
Oregon	OHP			MH SA			
Pennsylvania	HCBHS						MH SA
Rhode Island	RIteCare			MH SA			
South Carolina	N/A						
South Dakota	PRIME						MH SA
Tennessee	TennCare, Partners			MH SA			
Texas	STAR						MH SA
	NorthSTAR					MH SA	
Utah	PHMP						MH
Vermont	VHAP			MH SA			
Virginia	Medallion II						MH
Washington	Integrated Community Mental Health Program						MH
West Virginia	N/A						
Wisconsin	Medicaid HMO Program						MH SA
	BadgerCare	MH SA					
Wyoming	N/A						
TOTAL		1	1	18	2	3	24

MH = Mental Health. SA = Substance Abuse. N/A = State Does Not Have a Waiver That Includes MH/SA.
Full program titles and descriptions are provided in the State Profiles Section.

TABLE 2. STATUS OF NON-MEDICAID MANAGED BEHAVIORAL HEALTH CARE PROGRAMS—JULY 31, 1998

State	Mental Health	Substance Abuse	Mental Health and Substance Abuse	Child Welfare
Arizona				*Interagency Case Management Project:* Program for multisystem children involves child welfare, behavioral health, education, and juvenile justice agencies to improve the behavioral health care delivery system.
California	*Short-Doyle Program:* State-funded program provides county-managed mental health services to Medi-Cal-eligible and indigent individuals.			
Connecticut			*GA Behavioral Health Managed Care Program:* Provides mental health and substance abuse services to the general assistance population through a State interagency agreement.	
Delaware				*Child Welfare Demonstration:* Provides behavioral health services to families whose children might be placed in out-of-home care.
Florida		*Capitation Plan:* Provides funding to social service district offices for all social services, including substance abuse services.		*Department of Children and Families:* District offices of the Department, which administer State general fund programs for behavioral health, contract with Medicaid to coordinate diversion and aftercare efforts by community-based behavioral health care providers.
Georgia			*Community Service Board/ASO:* A local mental health and substance abuse program with an ASO arrangement operates in ten counties.	
Hawaii			*Children's Demonstration:* A single care management company provides behavioral health services to children with SED in a pilot program.	

TABLE 2. STATUS OF NON-MEDICAID MANAGED BEHAVIORAL HEALTH CARE PROGRAMS—JULY 31, 1998 (CONTINUED)

State	Mental Health	Substance Abuse	Mental Health and Substance Abuse	Child Welfare
Idaho		*Idaho Substance Abuse Services:* Managed behavioral health firm provides support and gatekeeping services on a managed fee-for-service basis.		
Indiana			1. *Hoosier Assurance Plan:* Provides services to adults and children through safety-net managed care providers. 2. *Dawn Project:* Pilot program to develop a coordinated, family-centered, community-based system of services for children with SED.	
Iowa	*County Program:* Counties are required by legislation to establish mental health managed care plan for non-Medicaid beneficiaries or services.			
Kansas		*Alcohol and Drug Managed Care Model:* Department of Social and Rehabilitation Services implemented tri-phase alcohol and drug managed care model that established five regional substance abuse assessment centers to provide onsite assessment services to all eligible.		*Children and Family Services Privatization:* Private vendor provides behavioral health care services to child welfare recipients; implemented by partnership between private non-profit provider and private managed behavioral health care firm.
Minnesota			1. *MinnesotaCare:* Provides limited mental health and substance abuse services for uninsured low-income recipients. 2. *General Assistance Medical Care Managed Care:* Provides limited mental health and substance abuse services to certain low-income adults who are not eligible for Medicaid.	

TABLE 2. STATUS OF NON-MEDICAID MANAGED BEHAVIORAL HEALTH CARE PROGRAMS—JULY 31, 1998 (CONTINUED)

State	Mental Health	Substance Abuse	Mental Health and Substance Abuse	Child Welfare
Missouri		*CSTAR:* Managed fee-for-service program combined with Medicaid dollars.		
Nebraska			*Behavioral Health Redesign:* Health and Human Services System, Department of Health and Human Services, has contracted with a private managed care organization under an ASO arrangement to manage care for State-operated inpatient psychiatric facilities and community behavioral health services.	
New Hampshire	*New Hampshire Department of Mental Health and Developmental Services:* Using administrative methods to manage public funds for adults with serious mental illness; uses a performance withhold for CMHC funding allocations.			
New York	*Prepaid Mental Health Plan:* State-operated facilities provide mental health services.	*County Demonstration on the Provision of Managed Addiction Treatment Services:* Tests new methods for administrating and financing State substance abuse services.		
Oregon	*Children's Intensive Mental Health Treatment Services:* Pilot program to integrate children's intensive mental health treatment into Medicaid waiver program.			

TABLE 2. STATUS OF NON-MEDICAID MANAGED BEHAVIORAL HEALTH CARE PROGRAMS—JULY 31, 1998 (CONTINUED)

State	Mental Health	Substance Abuse	Mental Health and Substance Abuse	Child Welfare
Rhode Island		*Detoxification Services:* Department of Health contracts with a substance abuse service provider to manage detoxification services; funded by block grants and general revenue.	*RI Cover:* Planned managed care program will provide physical and behavioral health services to individuals with SMI/SED.	
South Carolina				*Child Welfare Privatization Initiative:* Mental health managed care system for youth pilot project.
South Dakota	*CARE program:* Capitation program for individuals with SPMI and SED.			
Tennessee	*MHM Correctional Services, Inc.:* Managed correctional program provides mental health services to prison system.			
Texas	*Texas Integrated Funding Initiative:* Pooling public funds spent among state and local agencies on SED children; pilot.			
Vermont	*DDMHS Restructuring:* Effort to develop case rate funding mechanism for chronic mental health services.			
Virginia	*Priority Populations and Case Rate Funding Pilot:* Applies managed care techniques for planning individual services and delivery.			
Washington	*Basic Health Plan:* Provides limited mental health and substance abuse services to uninsured individuals.			
Total	11	6	9	5

ASO = Administrative Services Organization
CMHC = Community Mental Health Center
SED = Severe Emotional Disturbance
SMI = Serious Mental Illness
SPMI = Severe and Persistent Mental Illness

Some States have comprehensive programs for the public behavioral health care system (e.g., Nebraska, Indiana); while others have implemented single feature programs involving managed care tools such as interagency case management (e.g., Arizona), gatekeeping (e.g., Idaho), assessment/level of care determinations (Kansas, Missouri), and capitation (South Dakota). Two States (Vermont and New Hampshire) are redesigning their public mental health systems and are, among other things, moving toward new payment systems involving case rates, capitation, and performance funding. Still others target particular populations such as children with severe emotional disturbance (SED) (e.g., Hawaii, Indiana, Oregon, South Dakota, Texas), general assistance recipients (e.g., Connecticut), adults with serious mental illness (SMI) (e.g., Indiana), and child welfare recipients (e.g., Florida, Kansas, South Carolina). Several States are also piloting or planning programs with future plans to capitate services (e.g., Vermont, Rhode Island). Two States report county-operated, non-Medicaid programs (Georgia, Iowa).

Table 2 reflects *only* those programs that are exclusively non-Medicaid in nature. It should be noted however, that five States (Arizona, Massachusetts, Michigan, Montana, Texas) piggyback non-Medicaid populations 3 with Medicaid programs, essentially using the same managed care infrastructure for both program components.

Privatization Activities/ Managed Care Entities

Privatization refers to contracting with independent, nongovernmental entities to manage or provide behavioral health services under a State's managed care program. In this report privatization refers to the extent to which government/public roles and responsibilities are transferred or contracted to private sector organizations under managed care.

States contract with three types of managed care entities to operate their behavioral health plans: public, private, or public/private partnerships (see table 3). Private sector managed care entities are usually HMOs or commercial MCOs. MCOs and HMOs specialize in managed care programs for physical health services and may subcontract mental health and/or substance abuse services to community providers or private behavioral health managed care organizations (BHMCOs). BHMCOs are commercial managed care vendors that specialize in behavioral health services. Two types of partnerships have formed: BHMCOs with community providers or networks of providers and BHMCOs with counties/local government.

When managed care for behavioral health programs emerged, many experts predicted that private MCOs would take over responsibility for operating these programs for public sector clients, just as they had in the general health field. The data reported to SAMHSA Tracking for 1998 reveal that this prediction holds true for integrated health plans, but not for plans designed specifically for mental health and/or substance abuse. Privatization remains a stable force on the physical health side, but private sector organizations have not taken over as "managed care entities" in the behavioral health field.

Managed Care Entities for Integrated Health Plans

For most integrated managed care programs (76 percent), 27 States contract with private sector organizations as the managed care entity. Most of these contracts are with HMOs or MCOs responsible for administering physical rather than behavioral health programs. Although these programs include a component for mental health and substance abuse, they most often focus on physical health service, and are generally considered integrated programs (see the section on Managed Behavioral Health Care Program Design and Structure). These programs usually cover acute mental health and substance abuse services (e.g., inpatient, outpatient) that traditionally have been reimbursed under Medicaid's medical insurance program. Some States (e.g., Oregon) contract with both public and private entities for their integrated programs.

Managed Care Entities for Managed Care Programs Specific to Behavioral Health

Of 53 programs specific to mental health and/or substance abuse (i.e., stand-alone, carve-out, and partial carve-out), 30 programs in 26 States are managed by public sector agencies or public/private partnerships (57 percent). Different combinations of management arrangement exist. For example, four models in Colorado cut across public, private, and partnership approaches. Eight States contract with counties or other local government entities (California, Michigan, Minnesota, New York, North Carolina, Pennsylvania, Washington, Wisconsin); eight States contract with community providers (Arizona, Colorado, Indiana, Kansas, Michigan, Rhode Island, Utah, Virginia); and in five States, a State agency functions in some capacity as the managed care entity (Missouri, New Hampshire, New York, South Carolina,

Vermont). Six States contract with partnerships between community providers and BHMCOs (Arkansas, Colorado, Florida, Iowa, Kentucky, Montana); and three States contract with partnerships between government agencies and/or private BHMCOs (Delaware, Maryland, Pennsylvania). In comparison, 20 States contract with private sector organizations to run their behavioral health programs (see table 3).[6]

Administrative Services Only (ASO) Arrangements

An ASO is an arrangement under which an independent organization (e.g., private for-profit managed care organization, insurance carrier), performs administrative services for a managed care plan in exchange for a fee, without assuming any financial risk. ASO services may include claims processing, actuarial support, benefit plan design, financial advice, medical management, preparation of data for reports to governmental units, and other administrative functions. Ten States are involved in ASO arrangements.

Four States (Alaska, Florida, Nebraska, and Ohio) contract with private, for-profit organizations for a single administrative function (e.g., management information services, utilization review, prior authorization), while three (Connecticut, Kansas, and Maryland) contract most administrative services to private entities. One county in Colorado and several in Oregon and Texas have contracted with private entities under ASO arrangements.

Managed Behavioral Health Care Program Design and Structure

States use four structures for their managed behavioral health care programs: integrated, partial carve-out, full carve-out, and stand-alone. Integrated programs are physical health plans that include a mental health and substance abuse component, while the other three approaches are behavioral health care models designed specifically for mental health and/or substance abuse services.

Integrated Model—Mental health and substance abuse services are included with physical health services in a comprehensive, general, managed care program (table 4). The managed care contract is usually with a managed care organization (e.g., HMO, MCO). States typically use this approach for behavioral health services designed for a general population, such as Temporary Assistance for Needy Families (TANF) recipients, rather than a specialized population needing behavioral health care for long-term and more severe conditions. Thirty-five States operate 46 integrated programs.

Typically, HMOs and MCOs are responsible for operating these programs. However, the HMO or MCO may subcontract with a behavioral health specialty organization to deliver mental health and/or substance abuse services within a comprehensive plan. In today's vernacular, this approach is often referred to as "checkbook" integration because payment is integrated for health and behavioral health, while the provision of behavioral health services is subcontracted to a separate organization, with little involvement on the part of the State.

A new twist to the integrated approach is known as a *carve-in*: States either require the behavioral health organization to have a clinical relationship with the primary managed care entity or have other special requirements or reimbursement arrangements for HMOs delivering behavioral health services (New Mexico, Oklahoma, and Massachusetts).

Partial Carve-Out—States use an integrated approach for some mental health and/or substance abuse services, but place other, often expanded mental health and/or substance abuse services and/or populations under a separate managed care program (table 5). The intent of the partial carve-out program is to provide a basic set of behavioral health benefits under a comprehensive physical health plan (e.g., basic benefit plan), but to supplement them under a separate managed care program for special populations (e.g., children with SED, adults with SMI) whose needs go beyond those covered by the basic plan. Three States operate partial carve-out programs for both mental health and substance abuse services.

Full Carve-Out Model—States completely separate mental health and/or substance abuse services and/or populations from managed care programs for physical health services. Full carve-outs are usually associated with Medicaid waiver programs (table 6). Five States (Arizona, Hawaii, Massachusetts, Missouri, and Tennessee) operate full carve-out programs: four for behavioral health services, and one for substance abuse services only.

Stand-Alone Programs—Some states operate managed mental health and/or substance abuse programs that are independent of any other program (i.e., they are not carved out of a physical health program). Stand-alone

[6] It should also be noted, however, that half these States contract with private organizations under administrative-services-only arrangements, rather than giving them responsibility for both administrative and clinical functions.

TABLE 3. TYPES OF STATE-CONTRACTED MANAGED CARE ENTITIES—JULY 31, 1998

State	Program	Public	Private	Partnership
Alabama	BAY		HMO	
Alaska	Prior authorization		Peer review organization (ASO)	
Arizona	AHCCCS Carve-out	Regional behavioral health authorities		
	ICMP	State agency		
Arkansas	Benefit Arkansas			BHMCO and CMHCs
California	Medi-Cal Specialty Mental Health Services Consolidation	Counties		
	Two-Plan Model	Local agency	MCO	
	Short-Doyle Program	N/A		
Colorado	Mental Health	CMHC	HMO and ASO	BHMCO and CMHCs
	Integrated Care and Financing Pilot Project		HMO	
Connecticut	Connecticut Access		HMOs	
	GA Behavioral Health Managed Care Program		ASO	
Delaware	Diamond State Health Plan		MCOs	State agency and MCOs
	Child Welfare Demonstration	State agency		
District of Columbia	HSCSN		Provider network	
Florida	PMHP			MCO and CMHCs
	Department of Children and Families	Unknown		
	Capitation Plan	Unknown		
	Behavioral Health Care Utilization Management Service		Utilization review organization (ASO)	
Georgia	CSB/ASO	N/A		
Hawaii	Hawaii QUEST/CCS		BHMCO	
	Children's Demonstration		Care management organization	
Idaho	Idaho Substance Abuse Services		BHMCO	
Illinois	Responsible Choice		HMOs; prepaid health plans	
Indiana	HPPD		MCOs	
	Hoosier Assurance Plan	CMHCs	Addiction providers	
	Dawn Project		MCO	
Iowa	MHAP		BHMCO	
	IMSACP			Non-profit substance abuse service provider agency and BHMCO
	County Program	N/A		
Kansas	Alcohol and Drug Managed Care Model	Regional assessment centers	ASO	
	CFS Privatization		Providers	
Kentucky	Access			BHMCO and Providers
	Health Care Partnerships			Regional Partnerships

TABLE 3. TYPES OF STATE-CONTRACTED MANAGED CARE ENTITIES—JULY 31, 1998 (CONTINUED)

State	Program	Public	Private	Partnership
Louisiana	Pilot		HMOs	
Maine	N/A			
Maryland	HealthChoice		MCOs; BHMCO (ASO)	State agency and county agency
Massachusetts	MassHealth		HMOs; BHMCO	
Michigan	Comprehensive Health Plan		HMO; prepaid health plans	
	MSSP	Community mental health boards		
	MIFPI	Community mental health boards		
	Voluntary HMO	HMOs		
Minnesota	PMAP		HMOs; prepaid health plans	
	MSHO		HMOs	
	CCDTF	Counties		
	MinnesotaCare		HMOs; prepaid health plans	
	General Assistance Medical Care Managed Care		HMOs; prepaid health plans	
Mississippi	N/A			
Missouri	Managed Care +		HMO	
	CSTAR	State agency		
Montana	MHAP			BHMCO and providers
Nebraska	Nebraska Health Connection MH/SA		BHMCO	
	Medical/Surgical Component		Providers	
	Behavioral Health Redesign		MCO (ASO)	
Nevada	N/A			
New Hampshire	New Hampshire Managed Care		HMO	
	NHDMHDS	State agency		
New Jersey	MCCD	Hospitals	Hospitals	
New Mexico	SALUD!			HMOs and BHMCOs
New York	Partnership Plan		MCOs	
	Prepaid Mental Health Plan	State providers		
	County Demonstration	Counties		
North Carolina	Carolina Alternatives	County or regional mental health boards		
North Dakota	NoDAC		HMO	
Ohio	OhioCare		HMO	
	Accessing Better Care		HMO	
	URIP		ASO	
Oklahoma	SoonerCare		HMOs	
Oregon	OHP	Counties (MH)	HMOs; ASO	
	Children's Intensive Mental Health Treatment Services	Counties	HMOs	
Pennsylvania	HCBHS	Counties		Counties and BHMCO
	Voluntary HMO Contracts		HMOs	
Rhode Island	RIteCare		HMOs	
	Detoxification Services		Provider	
	RICover	CHMCs		

TABLE 3. TYPES OF STATE-CONTRACTED MANAGED CARE ENTITIES—JULY 31, 1998 (CONTINUED)

State	Program	Public	Private	Partnership
South Carolina	Voluntary HMO Program		HMOs	
	Child Welfare Privatization Initiative		MCO	
	Prior authorization	State agency (ASO)		
South Dakota	PRIME		Providers	
	CARE program		Providers	
Tennessee	TennCare Partners		BHMCOs	
	MHM Correctional Services, Inc.		BHMCO	
Texas	STAR		HMOs	
	NorthSTAR		HMOs	Limited-purpose HMOs
	Texas Integrated Funding Initiative		ASO	
Utah	PMHP	CMHCs		
Vermont	VHAP		BHMCO	Community providers and BHMCO
	DDMHS Restructuring	State agency		
Virginia	Medallion II		HMOs	
	Priority Populations and Case Rate Funding Pilot	Community service boards		
Washington	Integrated Community Mental Health Program	Single or multiple county administrative organizations		
	Basic Health Plan	HMOs		
West Virginia	New Directions in Medicaid Services Initiative		Providers	
Wisconsin	Medicaid HMO Program		HMOs	
	BadgerCare		HMOs	
	CCF	County agency		
	WAM	County agency		
	I-Care			HMO and community-based organization
	WI Partnership	Unknown		
	PACE	Unknown		
Wyoming	N/A			
Total Programs		28 programs	61 programs	14 programs

programs are usually associated with non-Medicaid programs, although some Medicaid waivers for mental health and/or substance abuse (table 6) are independent of any other program. Thirty-three States operate 45 stand-alone programs: 21 for mental health, 8 for substance abuse, and 16 for behavioral health.

Financing

Sources of Funding

Managed care programs are generally financed by six funding sources: Medicaid, block grants, State Department of Mental Health allocations, State Department of Alcohol and Drug Abuse allocations, general revenues, and county funds (table 7). Of the 89 managed care programs that reported financing information, 78 percent include Medicaid funding. Of those with Medicaid, 36 percent fund their programs with Medicaid dollars exclusively. General revenues are the next largest source of funding (44 percent), followed by block grants (18 percent), county funds (12 percent), State Department of Mental Health allocations (6 percent), and State Department of Alcohol and Drug Abuse allocations (3 percent). In 1999, we can expect Title XXI Children's Health Insurance Program (CHIP) funds to be a major new source of funding.

Risk and Payment Methods

A wide range of payment mechanisms is used in managed care systems, ranging from capitation to traditional fee-for-service (see below). Information reported to SAMHSA Tracking in 1998 shows that most States use some type of capitation payment to reimburse managed care contractors (MCCs). Of 47 States with some managed care activity, 41 contract with a managed care entity on a capitated basis for at least one of their programs; in the remaining 10 States, information is not available or the managed care entity or provider is not capitated (see table 8).

In some States, the MCC receives several types of payments (e.g., capitation for Medicaid recipients, State allocations for other non-Medicaid recipients; as in Montana, Arizona, Michigan). Moreover, some States have more than one MCC operating for the same program, and each may receive different types of payment (e.g., Colorado, Maryland, Massachusetts).

Information on the types of payment methods managed care entities use for providers was not reported for at least 30 percent of the programs. However, managed care entities are capitating mental health and/or substance abuse providers in one statewide Medicaid program (Oregon Health Plan) and one regional Medicaid program (Mobile, Alabama). Additionally, Vermont has recently launched a restructuring program involving a new payment system for providers serving clients with long-term mental health needs. The new payment system includes both capitation and case rates, depending upon the type of service rendered. Case rates are being used to pay providers in nine other programs. Vermont and New Hampshire have eliminated the MCC by directly paying providers on a case rate or capitation basis, thus placing the provider at risk, without an intervening MCC.

The payment methods generally used are capitation, case rate, global budget, negotiated fee, and fee-for-service.

- *Capitation (full and partial)*—a risk-sharing reimbursement methodology based on a preset per-member per-month payment to managed care entities for administration and/or service delivery. The central element of risk under the capitation payment is that the payment is fixed, regardless of the volume of services provided. Capitation contracts are complicated and can involve an extensive array of risks and risk protection provisions.
- *Case Rate*—a package price or single payment for all services associated with all care immediately before and after diagnosis of a condition. This method differs from fee-for-service in that providers receive only a single bundled payment for all the services provided across a multimonth timeframe as opposed to receiving a separate payment for each service rendered. It differs from capitation payments because each additional patient needing the procedure generates another bundled payment under the package price structure, but not under a capitation structure.
- *Global Budget*—a fixed budget for mental health and/or substance abuse. Under these terms, managed care entities and providers do not receive any additional funding if costs exceed budgeted payments. Global budgets can incorporate floating fee schedules. Floating fee schedules are a mechanism for balancing the need to stay within a fixed overall budget and the managed care entity's or provider's desire to be paid on a fee-for-service basis.
- *Negotiated Fee*—a discounted fixed fee. An explicit discount from the full charge level.
- *Fee-For-Service*—payment at the usual and customary rate, by service unit, procedure, visit, day, etc.

Behavioral Health Services Under Managed Care Programs

The SAMHSA Tracking System collected information on the types of services offered by different managed care programs (both Medicaid and non-Medicaid waiver programs).[7] Table 9 shows the actual data collected from each program.[8] Managed care programs cover a broad array of mental health and substance abuse services. In fact, of the 97 managed care programs, over three-quarters cover mental health inpatient and outpatient services. (Information was not available or applicable for 14 of these programs; therefore, the denominator is 83.) Half the programs cover mental health rehabilitation, one-third cover detoxification (acute, subacute, and/or ambulatory) services, and an additional one-fourth cover Institution for Mental Diseases (IMD) services (mental health and substance abuse residential services).

Of the 22 programs that are mental health specific, more than half cover inpatient and outpatient services. More than one-third of all mental health programs cover residential, crisis, rehabilitation, and support services, and only two programs cover IMD services. Of the six programs that are substance abuse specific, five cover detoxification and outpatient services, four cover residential services, and two cover opiate treatment services.

Of the 55 programs that cover mental health *and* substance abuse services, more than three-quarters cover mental health and substance abuse outpatient as well as mental health inpatient services. More than one-half cover rehabilitation and detoxification. More than one-third cover mental health residential, crisis, support, and IMD services and opiate treatment. One-quarter cover substance abuse residential services.

Ten States (Arizona, Colorado, Kentucky, Michigan, Montana, New Mexico, Pennsylvania, Tennessee, Utah, Washington) no longer have mental health and/or substance abuse services under a fee-for-service system (except for those provided to specific populations, e.g., American Indians, individuals dually eligible (Medicaid and Medicare); and special needs children), or they have very limited services remaining fee-for-service.

Populations

Table 10 highlights those populations covered under managed care programs. Individuals eligible for managed care tend to fall into one of the following categories: Aid to Families with Dependent Children (AFDC)/TANF, Supplemental Security Income (SSI) or ABD (Aged, Blind, Disabled), expanded Medicaid, general assistance, expanded women and children, and clinical criteria (see Appendix B for further information on these categories).

Of 90 managed care programs[9] in 45 States, 60 percent cover individuals eligible for TANF/AFDC, over half cover SSI or ABD recipients, over one-third cover expanded women and children populations, and approximately one-tenth cover general assistance and expanded Medicaid populations.[10] More than half are Medicaid plans, including some non-Medicaid programs that are piggybacked onto the Medicaid plan. Overall, a larger percentage of Medicaid programs cover AFDC/TANF, expanded Medicaid, and expanded women and children populations than non-Medicaid programs.

Lead Agencies

The SAMHSA Managed Care Tracking System found that in States where managed behavioral health care is covered by some type of managed care plan (Medicaid or non-Medicaid), Medicaid is the lead agency for 53 percent of the programs; therefore, mental health or substance abuse authorities either are the lead agency or share responsibility with Medicaid for 47 percent of the programs (table 11). Concerning Medicaid plans, mental health and substance abuse authorities either are the lead agency or share responsibility with Medicaid for 31 percent of the programs.

The extent of involvement on the part of mental health and substance abuse agencies largely depends on whether the program is an integrated health plan or a separate behavioral health plan designed specifically for mental health and/or substance abuse (i.e., a nonintegrated program). Medicaid agencies take the lead role for 78 percent of all integrated programs, compared

[7] In order to maintain consistency across programs, the SAMHSA Tracking System used broad categories of services to classify the services covered by each State's program(s). Many programs cover the same service but label it differently. The service definitions utilized are found in Appendix C. HCFA has elected to adopt these service definitions for use in future surveys of Medicaid benefits (SAMHSA Managed Care Tracking Project, The Lewin Group, 1998).

[8] For cross-reference purposes in table 9, a State's multiple programs are listed in the same order as they are listed in the State's profile. For example, Minnesota has five programs highlighted in its State profile; therefore, in table 9 Minnesota is listed five times, following the order used in the profile.

[9] Information was not available or applicable for seven programs, making the denominator here 90.

[10] Many Medicaid and non-Medicaid managed care programs cover more than one population category.

TABLE 4. STATES WITH INTEGRATED MODELS FOR BEHAVIORAL HEALTH CARE—JULY 31, 1998
(MEDICAID, NON-MEDICAID, VOLUNTARY)

State	Programs	Comments
Alabama	BAY	Only in one county.
Arizona	1. AHCCCS	For 18-, 19-, and 20-year-olds who are non-SMI; for elderly and physically disabled.
	2. ICMP	For multisystem children.
California	Two-Plan Model	Limited Medicaid SA in a 12-county program.
Colorado	Integrated Care and Financing Pilot Project	For elderly and younger disabled people in one county.
Connecticut	Connecticut Access	Acute mental health and substance abuse services only.
Delaware	Child Welfare Demonstration	SA treatment for parents of children on welfare.
District of Columbia	HSCSN	1115 waiver for children with SED.
Florida	Department of Children and Families Child Welfare Program	Diversion and aftercare services.
Illinois	Responsible Choice Voluntary Program	Basic MH and SA treatment; currently operating in two counties.
Indiana	Managed Care for Persons with Disabilities and Chronic Illness	Voluntary for AFDC/TANF, SSI, and SOBRA; serves people with mental illnesses, emotional disorders, and chemical addictions.
Kansas	CFS Privatization	Partnership that provides a full range of behavioral health services to child welfare clients.
Kentucky	Health Care Partnerships	Only acute detoxification for SA and crisis; primary MH treatment and prescription drugs for MH.
Louisiana	Pilot Program	Provides mental health services along with physical health in one region of the State.
Massachusetts	MassHealth	Only under HMO program; PCCM carved out.
Michigan	1. Comprehensive Health Plan	Provides physical health as well as limited outpatient mental health services.
	2. MIFPI	Voluntary program; provides behavioral health services to severely impaired multisystem children and adolescents.
	3. Voluntary HMO	Provides only limited outpatient mental health as part of physical health benefit.
Minnesota	1. Section 1115 PMAP	For Medicaid recipients.
	2. Section 1115 MSHO	For Medicaid- and Medicare-eligible individuals over age 65.
	3. MinnesotaCare	For uninsured working poor.
	4. General Assistance Medical Care Managed Care	For certain low-income adults not eligible for Medicaid.
Missouri	MC+	MH services in four areas of the State.
Nebraska	Nebraska Health Connection Medical/Surgical Component	Outpatient MH/SA services and prescription drugs.
New Hampshire	New Hampshire Managed Care	Provides basic MH and SA services across the State.
New Jersey	Managed Charity Care Demonstration	Charity hospitals provide limited MH and SA services to non-Medicaid population; voluntary program.
New Mexico	SALUD!	Health plans required to partner with organizations that specialize in managed behavioral health care.
North Dakota	NoDAC	Only in one county.
Ohio	1. OhioCare	Basic behavioral health services.
	2. Accessing Better Care	Voluntary program in two counties; provides basic behavioral health services for people with disabilities and chronic illness.
Oklahoma	SoonerCare	HMOs receive enhanced capitation for SMI/SED.
Oregon	1. OHP	Only in 8 counties for MH; statewide for SA services.
	2. Children's Intensive Mental Health Treatment Services	Intensive mental health services.

TABLE 4. STATES WITH INTEGRATED MODELS FOR BEHAVIORAL HEALTH CARE—JULY 31, 1998 (MEDICAID, NON-MEDICAID, VOLUNTARY) (CONTINUED)

State	Programs	Comments
Pennsylvania	*Voluntary HMO Contracts*	Includes behavioral health services in 11 of the 28 counties in which the program is operating; in these 11 countries the State's carve-out is not yet operational.
Rhode Island	*RIteCare*	Provides primary and preventive care including MH and SA treatment; excludes patients with SMI or SED.
South Carolina	*Voluntary HMO Program*	Provides acute MH and SA services up to $1,000.
South Dakota	*PRIME*	Acute MH services except for SED or SPMI; SA services for children under age 21 and pregnant women.
Texas	*STAR Health Plan*	Only MH (except case management and rehabilitation) and only in one of two models now being implemented in portions of the State.
Vermont	*VHAP*	Only acute behavioral health services.
Virginia	*Medallion II*	Provides limited MH services statewide.
Washington	*BHP*	Basic MH and substance abuse services to uninsured.
Wisconsin	1. *Medicaid HMO Program*	Acute MH and SA services.
	2. *BadgerCare*	*Provides system of care to uninsured and underinsured families.*
	3. *I-Care*	*Regional program for SSI recipients.*
	4. *WI Partnership*	*Regional program for SSI recipients.*
	5. *PACE*	Covers acute care MH and SA services to frail elderly individuals.
Total		46

SMI = Serious Mental Illness
SA = Substance Abuse
SED = Severe Emotional Disturbance
MH = Mental Health
AFDC/TANF = Aid to Families with Dependent Children/Temporary Assistance for Needy Families
SSI = Supplemental Security Income
SOBRA = Seventh Omnibus Budget Reconciliation Act
PCCM = Primary Care Case Management
HMO = Health Maintenance Organization
SPMI = Severe and Persistent Mental Illness

TABLE 5. STATES WITH PARTIAL CARVE-OUT MODELS FOR BEHAVIORAL HEALTH CARE—JULY 31, 1998

State	Description of Basic Plan	Description of Partial Carve-Out
Delaware—*Diamond State Health Plan*	Children—up to 30 units MH/SA outpatient. Adults—up to 30 units inpatient; 20 hours outpatient.	Full continuum of services including wraparound services for children. with SED. Adults with SMI in fee-for-service system.
Maryland—*HealthChoice*	Primary MH and SA services.	Specialty MH services managed by local core service agencies.
New York—*The Partnership Plan*	Primary MH and SA services.	MH and SA services for special needs populations.

MH = Mental Health
SA = Substance Abuse
SED = Severe Emotional Disturbance
SMI = Serious Mental Illness

TABLE 6. FULL CARVE-OUT/STAND-ALONE MENTAL HEALTH/SUBSTANCE ABUSE MANAGED CARE PROGRAMS—JULY 31, 1998

State	Carve-Out From Physical Health	Stand-Alone Mental Health	Stand-Alone Substance Abuse	Stand-Alone Behavioral Health
Alaska		*Prior Autharization Program:* Medicaid MH services statewide.		
Arizona	*Section 1115 AHCCCS:* Statewide; all children and adults with SMI or SED (mandatory).			
Arkansas		*Section 1915(b) Benefit Arkansas:* Children only; statewide (mandatory).		
California		1. *Section 1915(b) Medi-Cal Specialty MH Services Consalidatian:* Combined with State funds (Short-Doyle); statewide; adults and children (mandatory).		
		2. *Short-Doyle Program:* State-funded; provides reimbursement for county MH services to Medi-Cal-eligible and indigent individuals; statewide.		
Colorado		*Section 1915(b) Mental Health:* Statewide; adults and children (mandatory).		
Connecticut				*GA Behavioral Health Managed Care program:* Department of Mental Health and Substance Abuse Services contracts with ASO for utilization management and claims processing for general assistance population; statewide.
Florida		*Section 1915(b) PMHP:* In Tampa Bay area only; adults and children (mandatory).	*Capitatian Plan:* Local social service districts receive capitated funding for all social service programs funded by Medicaid and State allocations, including SA; statewide.	*Behaviaral Health Care Utilization Management Service:* Medicaid contracts with private utilization management firm to review inpatient psychiatric services for Medicaid recipients who remain in the fee-for-service system; statewide.

TABLE 6. FULL CARVE-OUT/STAND-ALONE MENTAL HEALTH/SUBSTANCE ABUSE MANAGED CARE PROGRAMS—JULY 31, 1998 (CONTINUED)

State	Carve-Out From Physical Health	Stand-Alone Mental Health	Stand-Alone Substance Abuse	Stand-Alone Behavioral Health
Georgia				*CSB/ASO program:* In 10 counties; individuals with mental illness, substance abuse, and mental retardation supported by State allocations.
Hawaii	*Section 1115 QUEST/CCS:* Combined with State funds; statewide; SMI and SED populations (mandatory).			*Children's Demonstration:* Child and Adolescent Mental Health Division contracts with a single care management company for services to children with SED; pilot demonstration; island of Hawaii.
Idaho			*Idaho Substance Abuse Services:* Gatekeeping and SA support services; statewide; uninsured children and adults (mandatory).	
Indiana				1. *Hoosier Assurance Plan:* State and block grant dollars combined; statewide; children and adults, uninsured and Medicaid-eligible (voluntary).
				2. *Dawn Project:* Blended funding project between State and county offices; county contracts with MCO to provide SA and MH services to children receiving SSI; implemented in one county.

TABLE 6. FULL CARVE-OUT/STAND-ALONE MENTAL HEALTH/SUBSTANCE ABUSE MANAGED CARE PROGRAMS (CONTINUED)

State	Carve-Out From Physical Health	Stand-Alone Mental Health	Stand-Alone Substance Abuse	Stand-Alone Behavioral Health
Iowa		1. *Section 1915(b) MHAP:* Statewide; children and adults (mandatory).		
		2. *County Program:* State legislature mandated all 99 counties to develop managed care plan for non-Medicaid beneficiaries and services; 4 counties implemented programs that blend funds; non-Medicaid.	*Section 1915(b) IMSACP:* Combined with State DPH dollars; statewide; children and adults (mandatory).	
Kansas			*Alcohol and Drug Managed Care Model:* Combines State and block grant dollars; statewide; children and adults (voluntary).	
Kentucky				*Section 1915(b) Access:* Regionally based; adults and children (mandatory).
Massachusetts	*Section 1115 MassHealth:* Combined with DMH funds; statewide; uninsured adults and children (mandatory).			
Michigan				*Section 1915(b) MSSP:* Combined with SA block grant and State general funds; statewide; adults and children (mandatory).
Minnesota			*Section 1915(b) CCDTF:* Combined with SA block grant and State general funds; statewide; adults and children (voluntary).	
Missouri	*CSTAR:* Division of Alcohol and Drug Abuse manages all Medicaid SA services for adults; managed fee-for-service; Phase I of managed care; statewide.			
Montana		*Section 1915(b) MHAP:* Combined with MH block grant and State general revenues; statewide; adults and children (mandatory).		

TABLE 6. FULL CARVE-OUT/STAND-ALONE MENTAL HEALTH/SUBSTANCE ABUSE MANAGED CARE PROGRAMS—JULY 31, 1998 (CONTINUED)

State	Carve-Out From Physical Health	Stand-Alone Mental Health	Stand-Alone Substance Abuse	Stand-Alone Behavioral Health
Nebraska				1. *Section 1915(b) Nebraska Health Connection MH/SA:* Statewide; children and adults (mandatory).
				2. *Behavioral Health Redesign:* State-operated inpatient psychiatric services; statewide (uninsured and underinsured).
New Hampshire		*NHDMHDS:* Community mental health centers receive performance-based funding; MH budget allocation; statewide (children and adults).		
New York		*Prepaid Mental Health Plan:* Services provided in State-operated facilities; statewide; adults and children (voluntary).	*County Demonstration on the Provision of Managed Addiction Treatment Services:* Demonstration to determine best way to organize and deliver SA services; two counties; children and adults.	
North Carolina				*Section 1915(b) Carolina Alternatives:* Serves children and adolescents; 32 out of 100 counties (mandatory).
Ohio		*URIP:* Medicaid utilization review for inpatient psychiatric services; statewide.		
Pennsylvania				*Section 1915(b) HCBHS:* Statewide phase-in; adults and children (mandatory).
Rhode Island		*RICover:* Pilot for disabled populations; statewide (voluntary).	*Detoxification services:* Combines State general revenue and block grant dollars; statewide; adults and children (voluntary).	
South Carolina		*Child Welfare Privatization Initiative:* Pilot for MH managed care system for youth; one region.	*Prior authorization:* Medicaid SA services; statewide; adults and children (mandatory).	

TABLE 6. FULL CARVE-OUT/STAND-ALONE MENTAL HEALTH/SUBSTANCE ABUSE MANAGED CARE PROGRAMS—JULY 31, 1998 (CONTINUED)

State	Carve-Out From Physical Health	Stand-Alone Mental Health	Stand-Alone Substance Abuse	Stand-Alone Behavioral Health
South Dakota		*CARE program:* Division of Mental Health caps provider payments for adults with SPMI; contracts specify maximum amounts; statewide (voluntary).		
Tennessee	*Section 1115 TennCare Partners:* Combined with State and local dollars; statewide; adults and children (mandatory).	*MHM Correctional Services, Inc.:* Individuals in correctional system; statewide.		
Texas		*Texas Integrated Funding Initiative:* State MH agency pilot to pool public funds (State and local) for children with SED and SA/dependency problems; ASO manages funds; three sites (urban, rural, and suburban).		*Section 1915(b) NorthSTAR:* Combined with State MH and SA funding and MH and SA block grants; seven counties; adults and children (mandatory).
Utah		*Section 1915(b) PMHP:* 25 out of 29 counties; adults and children (mandatory).		
Vermont		*DDMHS:* System-wide restructuring effort by Department of Developmental Disabilities and Mental Health Services that will combine Medicaid and State MH funds into a single financing system; involves case rates and capitation for certain services; formal functional and diagnostic criteria used to determine client eligibility.		
Virginia		*Priority Populations and Case Rate Funding Pilot:* State-only dollars; for SMI and SED; uninsured, under-insured; children and adults (voluntary).		
Washington		*Section 1915(b) Integrated Community Mental Health Program:* Combined with block grant and state-only money; 39 counties; adults and children (mandatory).		

TABLE 6. FULL CARVE-OUT/STAND-ALONE MENTAL HEALTH/SUBSTANCE ABUSE MANAGED CARE PROGRAMS—JULY 31, 1998 (CONTINUED)

State	Carve-Out From Physical Health	Stand-Alone Mental Health	Stand-Alone Substance Abuse	Stand-Alone Behavioral Health
West Virginia				*New Directions:* Funded by Medicaid; statewide; children and adults (voluntary); also general assistance populations; and public mental health clients.
Wisconsin				1. *Children Come First:* For population with SED and/or SMI in Dane County (voluntary).
				2. *WrapAround Milwaukee:* For population with SED and/or SMI in Milwaukee County (voluntary).
Total	5	21	8	16

MH = Mental Health
SMI = Serious Mental Illness
SED = Severe Emotional Disturbance
ASO = Administrative Services Only
CMHC = Community Mental Health Center
SA = Substance Abuse
MCO = Managed Care Organization
DPH = Department of Public Health
DMH = Department of Mental Health
SPMI = Severe and Persistent Mental Illness

State	Program	Medicaid	Block Grants	State DMH	State AOD	General Revenues	Other
Alabama	BAY	X					
Alaska	Prior authorization	Unknown					
Arizona	AHCCCS Carve-out	X	X			X	County
	ICMP*			X			Other State agencies
Arkansas	Benefit Arkansas	X				X	Title IV-E
California	Medi-Cal Specialty Mental Health Services Consolidation	X				X	
	Two-Plan Model	X					
	Short-Doyle Program*					X	
Colorado	Mental Health	X					
	Integrated Care and Financing Pilot Project	Unknown					
Connecticut	Connecticut Access	X					
	GA Behavioral Health Managed Care Program*					X	
Delaware	Diamond State Health Plan	X					
	Child Welfare Demonstration*						Title IV-E
District of Columbia	HSCSN	X					
Florida	PMHP	X					
	Department of Children and Families*					X	
	Capitation Plan*	X				X	
	Behavioral Health Care Utilization Management Service	X					
Georgia	CSB/ASO*			X	X		Other State agencies
Hawaii	Hawaii QUEST/CCS	X				X	S.H.I.P.
	Children's Demonstration*	Unknown					
Idaho	Idaho Substance Abuse Services*	Unknown					
Illinois	Responsible Choice**	X					
Indiana	HPPD**	X					
	Hoosier Assurance Plan*		X			X	
	Dawn Project*						Other State agency, county
Iowa	MHAP	X					County
	IMSACP	X	X		X		
	County Program*		X			X	County
Kansas	Alcohol and Drug Managed Care Model*		X			X	
	CFS Privatization*	X				X	Title IV-E
Kentucky	Access	X					
	Health Care Partnerships	X					
Louisiana	Pilot	X					
Maine	N/A						
Maryland	HealthChoice	X	X			X	State hospital funds

State	Program	Medicaid	Block Grants	State DMH	State AOD	General Revenues	Other
Massachusetts	MassHealth***	X		X			
Michigan	Comprehensive Health Plan	X					
	MSSP***	X	X			X	
	MIFPI	X					Title IV-E, county
	Voluntary HMO**	X					
Minnesota	PMAP	X					
	MSHO	X					Private grant
	CCDTF	X	X			X	
	MinnesotaCare***	X				X	Premiums
	General Assistance Medical Care Managed Care*					X	
Mississippi	N/A						
Missouri	Managed Care +	X					
	CSTAR*	X	X			X	
Montana	MHAP***	X	X			X	
Nebraska	Nebraska Health Connection MH/SA	X					
	Medical/Surgical Component	X					
	Behavioral Health Redesign*					X	
Nevada	N/A						
New Hampshire	New Hampshire Managed Care**	X					
	NHDMHDS*						
New Jersey	MCCD	X				X	
New Mexico	SALUD!	X					
New York	Partnership Plan	X				X	
	Prepaid Mental Health Plan*					X	
	County Demonstration*		X		X	X	County
North Carolina	Carolina Alternatives	X					
North Dakota	NoDAC	X					
Ohio	OhioCare	X					
	Accessing Better Care**	X					
	URIP	X					
Oklahoma	SoonerCare	X					
Oregon	OHP	X				X	
	Children's Intensive Mental Health Treatment Services*	Unknown					
Pennsylvania	HCBHS	X				X	County
	Voluntary HMO Contracts**	X					
Rhode Island	RIteCare	X					Title XXI
	Detoxification Services*		X			X	
	RICover*	X	X			X	
South Carolina	Voluntary HMO Program**	X		X	X	X	
	Child Welfare Privatization Initiative*	X				X	Title IV-E, Title IV-B
	Prior authorization	X					

State	Program	Medicaid	Block Grants	State DMH	State AOD	General Revenues	Other
South Dakota	PRIME	X				X	
	CARE program*	X				X	
Tennessee	TennCare Partners	X				X	County
	MHM Correctional Services, Inc.*	Unknown					
Texas	STAR	X				X	
	NorthSTAR***	X	X			X	Local
	Texas Integrated Funding Initiative*		X			X	Other State agencies, Title IV-E, Title IV-B, city, county
Utah	PMHP	X					
Vermont	VHAP	X				X	
	DDMHS Restructuring*	X				X	
Virginia	Medallion II	X					
	Priority Populations and Case Rate Funding Pilot*					X	
Washington	Integrated Community Mental Health Program	X	X			X	
	Basic Health Plan*					X	Premiums
West Virginia	New Directions in Medicaid Services Initiative	X					
Wisconsin	Medicaid HMO Program	X					
	BadgerCare	X				X	Premiums
	CCF**						County
	WAM**	X					Other State agency, county
	I-Care**	X					
	WI Partnership**	Unknown					
	PACE**	Unknown					
Wyoming	N/A						
Total		70	16	5	4	42	25

*Non-Medicaid Programs.
**Voluntary Program.
***Medicaid/Non-Medicaid Program.
DSH = Disproportionate Share Hospital Funds. S.H.I.P. = State Health Insurance Program.
DMH = Department of Mental Health. AOD = Department of Alcohol and Drug Abuse.
All programs without asterisks are Medicaid programs.

TABLE 8. PAYMENT METHODS FOR MANAGED CARE CONTRACTORS (MCCs) AND PROVIDERS—JULY 31, 1998

State	Program	Capitated	Negotiated/ Flat Fee	Global Budget	Fee-For-Service	Case Rate
Alabama	BAY	MCC, Provider				
Alaska	Prior authorization		MCC[1]			
Arizona	AHCCCS Carve-out	MCC, Provider[2]			Provider[2]	
	ICMP *			MCC		
Arkansas	Benefit Arkansas	MCC, Provider[2]			Provider[2]	Provider[2]
California	Medi-Cal Specialty Mental Health Services Consolidation			MCC	MCC, Provider	
	Two-Plan Model	MCC[3]				
	Short-Doyle Program*				MCC, Provider	
Colorado	Mental Health	MCC[4]			Provider	
	Integrated Care and Financing Pilot Project	Unknown				
Connecticut	Connecticut Access	MCC[4]				
	GA Behavioral Health Managed Care Program*		MCC[1]			
Delaware	Diamond State Health Plan	MCC[5], Provider[2]	Provider[2]			Provider[2]
	Child Welfare Demonstration*	Unknown				
District of Columbia	HSCSN	MCC			Provider	
Florida	PMHP	MCC[4]				
	Dept.. of Children & Families*	Unknown				
	Capitation Plan*	MCC[3]				
	Behavioral Health Care Utilization Management Service		MCC[1]			
Georgia	CSB/ASO*		MCC[1]			
Hawaii	Hawaii QUEST/CCS	MCC[5], MCC[4,5]			Provider	Provider
	Children's Demonstration*	Unknown				
Idaho	Idaho Substance Abuse Services*	Unknown				
Illinois	Responsible Choice**	MCC[4,5]			MCC[4,5]	
Indiana	HHPD**	MCC[4]				
	Hoosier Assurance Plan*	MCC[4,5]				MCC[4,5]
	Dawn Project*	MCC[3]				
Iowa	MHAP	MCC			Provider	
	IMSACP	MCC	Provider[6]		Provider[6]	
	County Program*	MCC[4,7]			Provider	
Kansas	Alcohol and Drug Managed Care Model*	MCC[3]				
	CFS Privatization*					Provider[8]
Kentucky	Access	MCC[3,4]				
	Health Care Partnerships	MCC[4]				
Louisiana	Pilot	MCC[4]				
Maine	N/A					
Maryland	HealthChoice	MCC[4,5], MCC[5]	MCC[1]	MCC[5]	Provider	
Massachusetts	MassHealth***	MCC[4,5], MCC[4]			Provider	
Michigan	Comprehensive Health Plan	MCC[4,5,9]	MCC[4,5,9]			
	MSSP***	MCC[3,4,5]	MCC[3,4,5]			
	MIFPI	MCC[3,4,5]				
	Voluntary HMO**	MCC[4], Provider[2]				

TABLE 8. PAYMENT METHODS FOR MANAGED CARE CONTRACTORS (MCCs) AND PROVIDERS—JULY 31, 1998 (CONTINUED)

State	Program	Capitated	Negotiated/ Flat Fee	Global Budget	Fee-For-Service	Case Rate
Minnesota	PMAP	MCC[4,5], Provider[2]				
	MSHO	MCC[4,5], Provider[2]				
	CCDTF			MCC		Provider
	MinnesotaCare***	MCC[4], Provider[2]				
	General Assistance Medical Care Managed Care*	MCC[4], Provider[2]				
Mississippi	N/A					
Missouri	Managed Care +	MCC[4]				
	CSTAR*				Provider	
Montana	MHAP***	MCC		MCC	Provider	
Nebraska	Nebraska Health Connection MH/SA	MCC			Provider	Provider
	Medical/Surgical Component		MCC[4]			
	Behavioral Health Redesign*		MCC[1]			
Nevada	N/A					
New Hampshire	New Hampshire Managed Care**	MCC[4]				
	NHDMHDS*			Provider		
New Jersey	MCCD			Provider		
New Mexico	SALUD!	MCC			Provider	
New York	Partnership Plan	MCC[3]				
	Prepaid Mental Health Plan*	MCC[4]				
	County Demonstration*	MCC			Provider	
North Carolina	Carolina Alternatives	MCC[3]				
North Dakota	NoDAC	MCC				
Ohio	OhioCare	MCC[4,5]				
	Accessing Better Care**	MCC[4]				
	URIP		MCC[1]			
Oklahoma	SoonerCare	MCC[4]				
Oregon	OHP	MCC[4,5], MCC[5], Provider				
	Children's Intensive Mental Health Treatment Services*	Unknown				
Pennsylvania	HCBHS	MCC			Provider	
	Voluntary HMO Contracts**	MCC[4]				
Rhode Island	RIteCare	MCC[4]				
	Detoxification Services*			MCC[4]		
	RICover*	Unknown				
South Carolina	Voluntary HMO Program**	MCC[4]				
	Child Welfare Privatization Initiative*	MCC[3]				
	Prior authorization	Unknown				
South Dakota	PRIME	Unknown				
	CARE program*		Provider			
Tennessee	TennCare Partners	MCC	Providers			
	MHM Correctional Services, Inc.*	MCC[3]				
Texas	STAR	MCC[4]				
	NorthSTAR***	MCC[3]				
	Texas Integrated Funding Initiative*		MCC[1]			Provider

TABLE 8. PAYMENT METHODS FOR MANAGED CARE CONTRACTORS (MCCs) AND PROVIDERS—JULY 31, 1998 (CONTINUED)

State	Program	Capitated	Negotiated/ Flat Fee	Global Budget	Fee-For-Service	Case Rate
Utah	PMHP	MCC[4]				
Vermont	VHAP	MCC[4]				
	DDMHS Restructuring*	Provider			Provider	Provider
Virginia	Medallion II	MCC[4]				
	Priority Populations and Case Rate Funding Pilot*					Provider
Washington	Integrated Community Mental Health Program	MCC[2,5]				
	Basic Health Plan*	MCC[3]				
West Virginia	New Directions in Medicaid Services Initiative				Provider	
Wisconsin	Medicaid HMO Program	MCC[4]				
	BadgerCare	MCC[4]			MCC[4]	
	CCF**	Unknown				
	WAM**	Unknown				
	I-Care**	MCC[3]				
	WI Partnership**	Unknown				
	PACE**	Unknown				
Wyoming	N/A					
Total		13 MCC	1 MCC[9]	4 MCC	2 MCC	1 MCC[4]
		1 MCC[2]	3 MCC[4]	1 MCC[4]	2 MCC[4]	1 MCC[5]
		38 MCC[4]	2 MCC[5]	1 MCC[5]	1 MCC[5]	6 Provider
		17 MCC[5]	1 MC[3]	2 Provider	18 provider	2 Provider[2]
		14 MCC[3]	8 MCC[1]		2 Provider[2]	1 Provider[8]
		1 MCC[7]	1 Provider		1 Provider[6]	
		3 Provider	1 Provider[2]			
		8 Provider[2]	1 Provider[6]			

*Non-Medicaid Program. **Voluntary Program. ***Medicaid/Non-Medicaid Program.

All program names without asterisks are Medicaid programs.

"N/A" refers to States with no managed care programs that include mental health and/or substance abuse.

"Unknown" refers to States that have managed care programs that include mental health and/or substance abuse but did not report information needed to complete the chart.

[1] The MCC is under an administrative services only (ASO) arrangement.
[2] The MCC has a choice of how to contract with providers. It can share risk through subcapitation, case rates, etc., with subcontractors or reimburse providers on a fee-for-service basis.
[3] Information for providers was not available.
[4] The MCC is also a provider.
[5] More than one MCC is contracted with for the program.
[6] Refers to different providers who are contracted with separately by the State or the MCC.
[7] One county mental health and substance abuse agency acts as MCC and provider. Other counties are under various types of arrangements and cannot be depicted in this chart.
[8] Information for the MCC was not available.
[9] The contract the State has with the MCC stipulates that either fee-for-service or a form of capitation can be used as a payment mechanism.

with 37 percent of all nonintegrated programs. This is consistent with the fact that the majority of integrated programs are Medicaid. On the other hand, mental health and substance abuse authorities are either the lead agency or share governance and oversight with Medicaid for 63 percent of nonintegrated programs. In the same vein, the majority of nonintegrated programs come out of the State mental health and substance abuse authorities.

County Roles

Ten States operate programs run by counties, mental health boards, or regional authorities (Arizona, California, Kansas, Michigan, New York, North Carolina, Oregon, Pennsylvania, Virginia, and Washington). County involvement has been more significant in mental health than in substance abuse programs as well as in Medicaid rather than non-Medicaid programs. County involvement is an area that we anticipate will generate additional information in the next 2 years.

Substance Abuse Prevention/ Mental Health Promotion

Other than early and periodic screening, diagnosis, and treatment, substance abuse prevention and mental health promotion services are generally not included in managed behavioral health care programs. This is an area that we anticipate will generate additional information in the next 2 years.

Welfare Reform

The SAMHSA Tracking System reviewed three issues related to how States are implementing welfare reform:

- Requiring drug testing for TANF recipients;
- Opting out of Federal requirements to deny welfare benefits to TANF recipients convicted of drug felonies; and
- Providing for mental health and/or substance abuse treatment in Welfare-to-Work plans.

Overall, 9 States have mandatory drug testing requirements for TANF recipients under certain circumstances, while 41 States do not.[11] One State has legislation pending on this issue. In addition, the majority of States did not opt out of Federal requirements to deny welfare benefits to TANF recipients convicted of drug felonies. On the other hand, 13 have decided to opt out of this provision and provide TANF to convicted drug felons. Finally, 34 States have submitted Welfare-to-Work plans, and 23 States have had their plans approved. Of the 23 approved plans, 11 include provisions for mental health and/or substance abuse treatment (table 12).

Evaluations

Many States have completed or are currently performing evaluations of their mental health and substance abuse programs. Although the scope and depth of such evaluations vary considerably from State to State, three dimensions are commonly assessed: cost, outcomes, and access. Definitions of these dimensions also vary. The measurement of cost in some States refers to cost of the program, while in other states it refers to cost of the service. In addition, measures of outcome range from consumer satisfaction to patient clinical status. Information is available or applicable for 39 States.

Information available suggests that 20 States have evaluated or are evaluating the cost of their programs. In addition, 33 States are evaluating or have evaluated outcomes, and 31 States are evaluating or have evaluated access to managed behavioral health care programs. Of the States that perform evaluations, 17 include all three dimensions (table 13).

The impetus for such evaluations can be explained by several factors. For the Section 1115 waivers, HCFA requires States to evaluate the first year of the program according to cost, outcomes, and access. Also, as funding for health care shrinks and more States use managed care programs, public managers are under increasing pressure to provide evidence of the efficacy and efficiency of these new approaches.[12] In addition, as managed care becomes more prevalent, stakeholders have become concerned that costs may be declining at the expense of adequate access and quality of care.

[11] National Governors' Association Center for Best Practices, Summary of Selected Elements of State Plans for Temporary Assistance for Needy Families (TANF), NGA Website, November 20, 1997.

[12] Urban Institute: New Federalism

TABLE 9. MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES UNDER MANAGED CARE PROGRAMS—JULY 31, 1998

State	Program	Inpatient Services	IMD Services	Crisis	Mental Health Residential	Mental Health Outpatient	Mental Health Rehabilitation	Mental Health Support	Outpatient Substance Abuse Services	Detoxification	Opiate Treatment Programs	Residential Substance Abuse Treatment Programs
Alabama	BAY	X				X			X			
Alaska	Prior authorization	X					X					
Arizona	AHCCCS Carve-out	X	X	X		X	X	X	X	X	X	
	ICMP	Unknown										
Arkansas	Benefit Arkansas	X		X	X	X	X	X	X	X		X
California	Medi-Cal Specialty Mental Health Services Consolidation	X		X	X	X	X	X				
	Two-Plan Model								X	X		X
	Short-Doyle Program	X			X		X	X				
Colorado	Mental Health	X	X	X	X	X	X	X				
	Integrated Care and Financing Pilot Project	Unknown										
Connecticut	Connecticut Access	X	X			X						
	GA Behavioral Health Managed Care Program	X				X				X		X
Delaware	Diamond State Health Plan	X		X	X	X	X	X	X	X	X	X
	Child Welfare Demonstration	Unknown										
District of Columbia	HSCSN	X	X			X	X		X			

TABLE 9. MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES UNDER MANAGED CARE PROGRAMS—JULY 31, 1998 (CONTINUED)

State	Program	Inpatient Services	IMD Services	Crisis	Mental Health Residential	Mental Health Outpatient	Mental Health Rehabilitation	Mental Health Support	Outpatient Substance Abuse Services	Detoxification	Opiate Treatment Programs	Residential Substance Abuse Treatment Programs
Florida	PMHP	X	X			X	X	X				
	Department of Children and Families	Unknown										
	Capitation Plan	Unknown										
	Behavioral Health Care Utilization Management Service	X										
Georgia	CSB/ASO	N/A[1]										
Hawaii	Hawaii QUEST/CCS	X	X	X		X	X	X	X	X	X	
	Children's Demonstration	Unknown										
Idaho	Idaho Substance Abuse Services	N/A[1]										
Illinois	Responsible Choice	X	X			X	X		X	X		X
Indiana	HHPD	X	X			X	X		X	X	X	X
	Hoosier Assurance Plan	X		X		X	X		X	X		
	Dawn Project	X		X	X	X	X	X	X	X		
Iowa	MHAP	X		X	X	X		X				
	IMSACP								X	X	X	X
	County Program	X			X	X		X				
Kansas	Alcohol and Drug Managed Care Model								X	X		X
	CFS Privatization	X		X		X	X	X	X	X		

TABLE 9. MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES UNDER MANAGED CARE PROGRAMS—JULY 31, 1998 (CONTINUED)

State	Program	Inpatient Services	IMD Services	Crisis	Mental Health Residential	Mental Health Outpatient	Mental Health Rehabilitation	Mental Health Support	Outpatient Substance Abuse Services	Detoxification	Opiate Treatment Programs	Residential Substance Abuse Treatment Programs
Kentucky	Access	X	X			X	X			X		
	Health Care Partnerships			X						X		
Louisiana	Pilot	X		X		X						
Maine	N/A	N/A										
Maryland	HealthChoice	X				X			X	X	X	X
Massachusetts	MassHealth	X	X	X	X	X	X	X	X	X	X	X
Michigan	Comprehensive Health Plan					X						
	MSSP	X		X	X	X	X	X	X		X	X
	MIFPI					X			X			
	Voluntary HMO					X						
Minnesota	PMAP	X				X	X	X	X		X	
	MSHO	X	X			X	X		X		X	
	CCDTF		X			X	X	X	X		X	X
	MinnesotaCare	X	X			X	X	X	X		X	X
	General Assistance Medical Care Managed Care	X				X	X	X	X		X	
Mississippi	N/A	N/A										
Missouri	Managed Care +	X				X	X					
	CSTAR					X			X			X
Montana	MHAP	X		X	X	X	X	X				
Nebraska	Nebraska Health Connection MH/SA	X	X	X	X	X	X		X			X
	Medical/Surgical Component					X			X			
	Behavioral Health Redesign	X	X	X	X	X	X	X	X	X	X	X

TABLE 9. MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES UNDER MANAGED CARE PROGRAMS—JULY 31, 1998 (CONTINUED)

State	Program	Inpatient Services	IMD Services	Crisis	Mental Health Residential	Mental Health Outpatient	Mental Health Rehabilitation	Mental Health Support	Outpatient Substance Abuse Services	Detoxification	Opiate Treatment Programs	Residential Substance Abuse Treatment Programs
Nevada	N/A	N/A										
New Hampshire	New Hampshire Managed Care	X			X				X			
	NHDMHDS	N/A[2]										
New Jersey	MCCD	X							X	X	X	X
New Mexico	SALUD!	X				X	X		X			
New York	Partnership Plan	X		X		X	X	X	X	X		
	Prepaid Mental Health Plan	X				X						
	County Demonstration	Unknown										
North Carolina	Carolina Alternatives	X	X	X		X			X	X		
North Dakota	NoDAC	X				X	X		X			
Ohio	OhioCare	X				X			X	X	X	
	Accessing Better Care	X		X		X		X			X	
	URIP	N/A[1]										
Oklahoma	SoonerCare	X		X		X	X		X	X		
Oregon	OHP	X	X	X		X	X	X	X		X	
	Children's Intensive Mental Health Treatment Services				X	X						
Pennsylvania	HCBHS	X		X	X	X	X		X	X		
	Voluntary HMO Contracts	X				X	X		X	X		
Rhode Island	RiteCare				X	X			X		X	X
	Detoxification Services									X		
	RICover	N/A[1]										

TABLE 9. MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES UNDER MANAGED CARE PROGRAMS—JULY 31, 1998 (CONTINUED)

State	Program	Inpatient Services	IMD Services	Crisis	Mental Health Residential	Mental Health Outpatient	Mental Health Rehabilitation	Mental Health Support	Outpatient Substance Abuse Services	Detoxification	Opiate Treatment Programs	Residential Substance Abuse Treatment Programs
South Carolina	Voluntary HMO Program	X		X	X	X	X	X	X			X
	Child Welfare Privatization Initiative	Unknown										
	Prior authorization								X	X		
South Dakota	PRIME	X				X			X			
	CARE program			X	X	X	X	X				
Tennessee	TennCare Partners	X		X	X	X	X	X	X	X		
	MHM Correctional Services, Inc.					X						
Texas	STAR	X				X			X			
	NorthSTAR	X				X	X		X	X		X
	Texas Integrated Funding Initiative							X				
Utah	PMHP	X				X	X					
Vermont	VHAP	X		X	X	X	X	X	X	X		X
	DDMHS Restructuring		N/A[1]									
Virginia	Medallion II	X				X						
	Priority Populations and Case Rate Funding Pilot				X		X					

TABLE 9. MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES UNDER MANAGED CARE PROGRAMS—JULY 31, 1998 (CONTINUED)

State	Program	Inpatient Services	IMD Services	Crisis	Mental Health Residential	Mental Health Outpatient	Mental Health Rehabilitation	Mental Health Support	Outpatient Substance Abuse Services	Detoxification	Opiate Treatment Programs	Residential Substance Abuse Treatment Programs
Washington	Integrated Community Mental Health Program	X		X		X	X	X				
	Basic Health Plan	X				X			X			X
West Virginia	New Directions in Medicaid Services Initiative					X	X		X			X
Wisconsin	Medicaid HMO Program	X	X		X	X	X	X	X	X	X	
	BadgerCare	X	X	X	X	X	X	X	X	X	X	
	CCF	X	X	X	X	X	X	X	X	X	X	
	WAM	X	X	X	X	X	X	X	X	X	X	
	I-Care	X	X	X	X	X	X	X	X	X	X	
	WI Partnership	X	X	X	X	X	X	X	X	X	X	
	PACE	X	X	X	X	X	X	X	X	X	X	
Wyoming	N/A	N/A										
Total		64	24	34	29	70	50	36	55	38	26	23

This program serves a gatekeeping, utilization review, or administrative function only; no direct services are provided.

TABLE 10. ELIGIBLE POPULATIONS IN MANAGED BEHAVIORAL HEALTH CARE PROGRAMS—JULY 31, 1998

State	Program	AFDC/ TANF	SSI or ABD	Expanded Medicaid	General Assistance	Expanded Women and Children	Clinical Criteria	Dually Eligible Medicaid/ Medicare
Alabama	BAY	X	X			X		
Alaska	Prior authorization	N/A						
Arizona	AHCCCS Carve-out	X	X			X		
	ICMP*						C	
Arkansas	Benefit Arkansas	C						
California	Medi-Cal Specialty Mental Health Services Consolidation	X	X				X	
	Two-Plan Model	Unknown						
	Short-Doyle Program*	X	X					
Colorado	Mental Health	X	X			X		
	Integrated Care and Financing Pilot Project							X
Connecticut	Connecticut Access	X	X			X		
	GA Behavioral Health Managed Care Program*				X			
Delaware	Diamond State Health Plan	X	X			X		
	Child Welfare Demonstration*						C	
District of Columbia	HSCSN		C					
Florida	PMHP	X	X			X		
	Department of Children and Families*	C	C			C		
	Capitation Plan*	Unknown						
	Behavioral Health Care Utilization Management Service	N/A						
Georgia	CSB/ASO*						X	
Hawaii	Hawaii QUEST/CCS	X	X	X	X	X	X	
	Children's Demonstration*						X	
Idaho	Idaho Substance Abuse Services*	N/A						
Illinois	Responsible Choice**	X			C			
Indiana	HHPD**		X					
	Hoosier Assurance Plan*	X	X	X		X		
	Dawn Project*		X					
Iowa	MHAP	X	X			X		
	IMSACP	X	X			X		
	County Program*						A	
Kansas	Alcohol and Drug Managed Care Model*		X					
	CFS Privatization*	C					C	
Kentucky	Access	X	X			X		
	Health Care Partnerships	X	X			X		
Louisiana	Pilot	X						
Maine	N/A							
Maryland	HealthChoice	X	X	X		X		
Massachusetts	MassHealth***	X	X	X		X		

State	Program	AFDC/ TANF	SSI or ABD	Expanded Medicaid	General Assistance	Expanded Women and Children	Clinical Criteria	Dually Eligible Medicaid Medicare
Michigan	Comprehensive Health Plan	X	X			X		
	MSSP***	A	A				A	X
	MIFPI					C		
	Voluntary HMO**	X	X					
Minnesota	PMAP	X						
	MSHO						A	A
	CCDTF	X	X	X		X		
	MinnesotaCare***			X	X	X		
	General Assistance Medical Care Managed Care*				X			
Mississippi	N/A							
Missouri	Managed Care +	X	X			X		
	CSTAR*						X	
Montana	MHAP***	X	X		X	X	X	
Nebraska	Nebraska Health Connection MH/SA	X	X			X		
	Medical/Surgical Component	X	X			X		
	Behavioral Health Redesign*	X		X				
Nevada	N/A							
New Hampshire	New Hampshire Managed Care**						X	
	NHDMHDS*						X	
New Jersey	MCCD						X	
New Mexico	SALUD	X	X			X		
New York	Partnership Plan	X			X			
	Prepaid Mental Health Plan*	X						
	County Demonstration*						X	
North Carolina	Carolina Alternatives	C	C			C		
North Dakota	NoDAC	X						
Ohio	OhioCare	X						
	Accessing Better Care**		X					
	URIP	N/A						
Oklahoma	SoonerCare	X						
Oregon	OHP	X	X		X	X	X	
	Children's Intensive Mental Health Treatment Services*					C	C	
Pennsylvania	HCBHS	X	X		X	X		
	Voluntary HMO Contracts**	X	X		X		X	
Rhode Island	RIteCare	X				X		
	Detoxification Services*			X				
	RICover*						X	
South Carolina	Voluntary HMO Program**	X	X			X		
	Child Welfare Privatization Initiative*						X	
	Prior authorization	X						
South Dakota	PRIME	X	X			X		
	CARE program*						A	

State	Program	AFDC/ TANF	SSI or ABD	Expanded Medicaid	General Assistance	Expanded Women and Children	Clinical Criteria	Dually Eligible Medicaid Medicare
Tennessee	TennCare Partners	X	X			X	X	
	MHM Correctional Services, Inc.*						A	
Texas	STAR	X	X			X		
	NorthSTAR***	X	X			X		
	Texas Integrated Funding Initiative*						X	
Utah	PMHP	X	X			X	X	
Vermont	VHAP	X	X			X		X
	DDMHS Restructuring*						X	
Virginia	Medallion II	X	X					
	Priority Populations and Case Rate Funding Pilot*			X				
Washington	Integrated Community Mental Health Program	X	X			X		
	Basic Health Plan*	X	X					
West Virginia	New Directions In Medicaid Services Initiative	X	X		X			
Wisconsin	Medicaid HMO Program	X				X		X
	BadgerCare	Unknown						
	CCF**	C						
	WAM**	C						
	I-Care**		X					X
	WI Partnership**		A					X
	PACE**		A					X
Wyoming	N/A							
Total		57	48	9	11	38	28	8

* Non-Medicaid Programs. ** Voluntary Programs. ***Both Medicaid and Non-Medicaid Programs (i.e., "piggybacked" programs).
A = Adults. C = Children. X = Adults and Children.
1. AFDC/TANF = Aid to Families with Dependent Children/Temporary Assistance for Needy Families.
2. SSI = Supplemental Security Income.
3. ABD = Aged, Blind, Disabled.

TABLE 11. LEAD AGENCIES FOR PUBLIC SECTOR MANAGED BEHAVIORAL HEALTH CARE PROGRAMS—JULY 31, 1998

State	Program	Medicaid	Mental Health Authority	Substance Abuse Authority	Agency Partnership
Alabama	BAY	X			
Alaska	Prior authorization	X			
Arizona	AHCCCS Carve-out	X			
	ICMP		X		
Arkansas	Benefit Arkansas				Medicaid + MH
California	Medi-Cal Specialty Mental Health Services Consolidation		X		
	Two-Plan Model	X			
	Short-Doyle Program		X		
Colorado	Mental Health		X		
	Integrated Care and Financing Pilot Project	X			
Connecticut	Connecticut Access	X			
	GA Behavioral Health Managed Care Program				MH + SA
Delaware	Diamond State Health Plan	X			
	Child Welfare Demonstration		X		
District of Columbia	HSCSN	X			
Florida	PMHP	X			
	Department of Children and Families				MH + SA
	Capitation Plan	Unknown			
	Behavioral Health Care Utilization Management Service	X			
Georgia	CSB/ASO				MH + SA
Hawaii	Hawaii QUEST/CCS	X			
	Children's Demonstration	X			
Idaho	Idaho Substance Abuse Services				Medicaid + SA
Illinois	Responsible Choice	X			
Indiana	HPPD	X			
	Hoosier Assurance Plan		X		
	Dawn Project				MH + County + Education Department
Iowa	MHAP				Medicaid + MH
	IMSACP				Medicaid + SA
	County Program				Non-profit Organizations
Kansas	Alcohol and Drug Managed Care Model				Medicaid + SA
	CFS Privatization				Medicaid + MH
Kentucky	Access	X			
	Health Care Partnerships	X			
Louisiana	Pilot	X			
Maine	N/A				
Maryland	HealthChoice	X[1]	X[1]		
Massachusetts	MassHealth	X			
Michigan	Comprehensive Health Plan	X			
	MSSP				Medicaid + MH + SA
	MIFPI	X			
	Voluntary HMO	X			

TABLE 11. LEAD AGENCIES FOR PUBLIC SECTOR MANAGED BEHAVIORAL HEALTH CARE PROGRAMS—JULY 31, 1998 (CONTINUED)

State	Program	Medicaid	Mental Health Authority	Substance Abuse Authority	Agency Partnership
Minnesota	PMAP	X			
	MSHO				Medicaid + Aging
	CCDTF				Medicaid + SA
	MinnesotaCare	X			
	General Assistance Medical Care Managed Care	X			
Mississippi	N/A				
Missouri	Managed Care +	X			
	CSTAR				Medicaid + MH
Montana	MHAP				Medicaid + MH
Nebraska	Nebraska Health Connection MH/SA				Medicaid + MH + SA
	Medical/Surgical Component	X			
	Behavioral Health Redesign				Medicaid + MH + SA
Nevada	N/A				
New Hampshire	New Hampshire Managed Care	X			
	NHDMHDS		X		
New Jersey	MCCD			X	
New Mexico	SALUD!	X			
New York	Partnership Plan				Medicaid + MH
	Prepaid Mental Health Plan		X		
	County Demonstration			X	
North Carolina	Carolina Alternatives	X			
North Dakota	NoDAC	X			
Ohio	OhioCare	X			
	Accessing Better Care	X			
	URIP	X			
Oklahoma	SoonerCare	X			
Oregon	OHP				Medicaid + MH + SA
	Children's Intensive Mental Health Treatment Services		X		
Pennsylvania	HCBHS				MH + SA
	Voluntary HMO Contracts	X			
Rhode Island	RIteCare	X			
	Detoxification Services			X	
	RICover		X		
South Carolina	Voluntary HMO Program	X			
	Child Welfare Privatization Initiative	X			
	Prior authorization			X	
South Dakota	PRIME	X			
	CARE program		X		
Tennessee	TennCare Partners	X			
	MHM Correctional Services, Inc.				Department of Corrections
Texas	STAR	X			
	NorthSTAR				MH + SA
	Texas Integrated Funding Initiative	Unknown			

TABLE 11. LEAD AGENCIES FOR PUBLIC SECTOR MANAGED BEHAVIORAL HEALTH CARE PROGRAMS—JULY 31, 1998 (CONTINUED)

State	Program	Medicaid	Mental Health Authority	Substance Abuse Authority	Agency Partnership
Utah	PMHP	X			
Vermont	VHAP	X			
	DDMHS Restructuring		X		
Virginia	Medallion II	X			
	Priority Populations and Case Rate Funding Pilot				MH + SA
Washington	Integrated Community Mental Health Program		X		
	Basic Health Plan	Unknown			
West Virginia	New Directions in Medicaid Services Initiative	X			
Wisconsin	Medicaid HMO Program	X			
	BadgerCare	X			
	CCF	X			
	WAM	X			
	I-Care	Unknown			
	WI Partnership	Unknown			
	PACE	Unknown			
Wyoming	N/A				
Total		50	14	4	24

MH = Mental Health. SA = Substance Abuse.

[1] The Medicaid Agency is responsible for substance abuse and primary mental health services; the Mental Health Authority is responsible for specialty mental health services covered under the partial carve-out.

TABLE 12. WELFARE REFORM AND SUBSTANCE ABUSE TREATMENT—JULY 31, 1998

State	Provisions for Drug Testing in TANF	Provisions to Opt Out of Federal Requirements Denying TANF to Convicted Drug Felons	Provisions for MH and SA Treatment in Welfare-to-Work Plan
Alabama	No	No	N/A
Alaska	No	Yes	N/A
Arizona	No	No	N/A
Arkansas	No	No	N/A
California	No	No	Yes
Colorado	No	Yes[1]	N/A
Connecticut	No	Yes	N/A
Delaware	No	No	Yes
District of Columbia	No	No	N/A
Florida	No	Yes[2]	N/A
Georgia	No	No	Yes
Hawaii	No	Yes	Yes
Idaho	No	No	Unknown
Illinois	No	No	Unknown
Indiana	No	No	N/A
Iowa	No	Yes[1]	N/A
Louisiana	No[3]	No	No
Kansas	Yes[4]	No	No
Kentucky	No	No	No
Maine	No	No	N/A
Maryland	No	No	Yes
Massachusetts	No	No	No
Michigan	No	Yes[5]	Yes
Minnesota	Yes	Yes	Yes
Mississippi	No	No	N/A
Missouri	No	No	Unknown
Montana	No	No	N/A
Nebraska	No	No	Yes
Nevada	Yes	No	Yes
New Hampshire	No	Yes	No
New Jersey	No	No	N/A
New Mexico	No	No	N/A
New York	Yes[6]	Yes	N/A
North Carolina	Yes	No	N/A
North Dakota	No	No	N/A
Ohio	Yes[7]	No	Yes[8]
Oklahoma	No	No	N/A
Oregon	No	No	N/A
Pennsylvania	Yes	No	N/A
Rhode Island	Yes	No	Yes
South Carolina	Yes	No	Yes
South Dakota	No	No	Yes
Tennessee	No	No	No
Texas	No	No	N/A

State	Provisions for Drug Testing in TANF	Provisions to Opt Out of Federal Requirements Denying TANF to Convicted Drug Felons	Provisions for MH and SA Treatment in Welfare-to-Work Plan
Utah	No	Yes[9]	N/A
Vermont	No	Yes	N/A
Virginia	No	No	N/A
Washington	No	Yes[10]	N/A
West Virginia	No	No	N/A
Wisconsin	Legislation pending	No	N/A
Wyoming	No	Yes	N/A

[1] Benefits will continue to be provided only if individual is in rehabilitation.

[2] Except drug traffickers.

[3] State is in planning stages to test for drug use.

[4] State will screen all applicants for substance abuse and will refer clients for more extensive testing, if necessary. A drug test may be administered as part of the expanded testing.

[5] Benefits must be paid through a third-party payor contingent upon the individual meeting parole requirements.

[6] State conducts mandatory drug assessment for all applicants and recipients upon recertification. The assessment may include a drug test.

[7] For certain pregnant Medicaid recipients.

[8] Ohio declined Welfare-to-Work (WtW) funds after its WtW plan was approved.

[9] State requires drug felons to receive treatment and makes progress as a condition for receiving benefits.

[10] State will provide benefits to drug felons with certain limitations.

MH = Mental Health. SA = Substance Abuse. TAN F = Temporary Assistance for Needy Families. N/A = Not Applicable.

TABLE 13. DIMENSIONS OF MANAGED BEHAVIORAL HEALTH CARE EVALUATIONS—JULY 31, 1998

State	Cost	Outcomes	Access
Alabama	X	X	X
Alaska		N/A	
Arizona		X	
Arkansas		X	
California		X	X
Colorado	X		
Connecticut	X	X	X
Delaware		X	X
District of Columbia	X	X	X
Florida	X	X	X
Georgia		N/A	
Hawaii		X	X
Idaho		N/A	
Illinois			X
Indiana	X		
Iowa		X	X
Louisiana	X		
Kansas		X	
Kentucky	X	X	X
Maine		N/A	
Maryland		X	X
Massachusetts	X	X	X
Michigan	X	X	X
Minnesota	X	X	X
Mississippi		N/A	
Missouri		Unknown	
Montana		Unknown	
Nebraska		X	X
Nevada		N/A	
New Hampshire	Reporting and continuous quality improvement reports required.		
New Jersey		X	X
New Mexico		In process	
New York	X	X	
North Carolina	X	X	X
North Dakota		N/A	
Ohio		X	X
Oklahoma		X	X
Oregon	X	X	X
Pennsylvania	X	X	X
Rhode Island	X	X	X
South Carolina	X	X	X
South Dakota		X	X
Tennessee	X	X	X
Texas		X	X
Utah	X	X	X
Vermont	X	X	X
Virginia		X	X
Washington	X	X	X
West Virginia		Unknown	
Wisconsin		Unknown	
Wyoming		N/A	
Total	20	33	31

NA = Not Applicable.

ALABAMA

OVERVIEW

Medicaid-funded behavioral health services remain in the fee-for-service system in Alabama, except in Mobile County. In that county, the Better Access for You (BAY) Health Plan integrates behavioral health into a primary care model and provides all of the mandatory Medicaid benefits without copayments, deductibles, or cost sharing.

Although a statewide managed care strategy for behavioral health has not been adopted, State officials are considering a major mental health reform effort that would embrace some managed care concepts.

Managed Care Programs for Behavioral Health Services

MEDICAID WAIVERS

Section 1115 - BAY - general health - integrated: Physical health, mental health, and substance abuse services are integrated into general managed health care services.

MEDICAID VOLUNTARY

Not applicable.

OTHER MANAGED CARE PROGRAMS

Not applicable.

Geographic Location

Section 1115 - BAY: Mobile County only.

Status of Programs

Section 1115 - BAY: Waiver submitted: Date not available. Waiver approved: December 6, 1996. Waiver implemented: May 1, 1997.

Medicaid Substance Abuse Services Remaining Fee-For-Service

Crisis; outpatient (e.g., individual, group, and family counseling and therapy).

Medicaid Mental Health Services Remaining Fee-For-Service

Inpatient; outpatient (e.g., clinic services); mental health rehabilitation (e.g., targeted case management, psychiatric rehabilitation); Institution for Mental Diseases (IMD) services for individuals age 65 and over and age 21 and under; prescription drugs. Per Omnibus Budget Reconciliation Act (OBRA) 90, all drugs with a valid rebate agreement with the Health Care Financing Administration (HCFA) are covered by the State.

Medicaid Substance Abuse Services in Managed Care Plan

Section 1115 - BAY: Crisis; outpatient (e.g., individual, group, and family counseling and therapy).

Medicaid Mental Health Services in Managed Care Plan

Section 1115 - BAY: Inpatient; outpatient (e.g., clinic services); mental health rehabilitation (e.g., targeted case management, psychiatric rehabilitation); IMD services for individuals age 65 and over and age 21 and under; prescription drugs. Per OBRA 90, all drugs with a valid rebate agreement with HCFA are covered by the State.

Non-Medicaid Substance Abuse Services in Managed Care Plan

Not applicable.

Non-Medicaid Mental Health Services in Managed Care Plan

Not applicable.

Substance Abuse Prevention and Mental Health Promotion in Managed Care Plan

Section 1115 - BAY: Early and periodic screening, diagnosis, and treatment (EPSDT).

Populations Covered Under Managed Behavioral Health

Section 1115 - BAY: Children and adults mandatory: Aid to Families with Dependent Children/ Temporary Assistance for Needy Families (AFDC/TANF), Seventh Omnibus Budget Reconciliation Act (SOBRA), Supplemental Security Income, optional expansion for pregnant women and children, uninsured and underinsured. BAY eligibles follow the same criteria for fee-for-service except for extended family planning. This extends family planning coverage for 2 years past delivery for SOBRA adults (133 percent Federal poverty level (FPL)). Children's Health Insurance Program (CHIP) children age 15 through 18 are covered in BAY (up to 100 percent FPL).

State Managed Care Program Administration

Section 1115 - BAY: The Medicaid agency contracts with a federally qualified nonprofit health maintenance organization (HMO). The HMO subcontracts all behavioral health services to a local public mental health center, which provides all mental health services for BAY Health Plan enrollees. The Department of Public Health provides oversight over Mobile Mental Health, a community mental health center. All community mental health providers covered by Medicaid participate. Other mental health providers, e.g., psychiatrists and substance abuse service providers, may participate if they are traditional providers following the 80/20 standard.

Financing of Plans

Section 1115 - BAY: BAY is financed through Medicaid dollars. The HMO bears risk up to a $600,000 stop-loss and is paid a capitated rate, which includes mental health services. The HMO contracts with Mobile Mental Health on a capitated basis. Mobile Mental Health is at full risk. The capitation rate was determined by historical expenditures. The State's anticipated savings is 3 percent of its projected budget neutrality cap. Providers are paid on a fee-for-service basis.

Coordination Between Primary and Behavioral Health Care

Section 1115 - BAY: Coordination of services is provided by the HMO, which refers patients to mental health services in Mobile County.

Consumer-Family Involvement

Section 1115 - BAY: Consumers were involved in the development of the 1115 waiver, and there is consumer oversight for BAY Health Plan. Consumers are on the community advising committee.

Future Plans

Section 1115 - BAY: None.

State Agency Administration

Medicaid is a single State agency. The mental health and substance abuse authorities are under the Department of Mental Health and Mental Retardation.

Welfare Reform

Alabama's welfare reform program denies TANF benefits to drug felons, but does not test recipients for drug use.

County

Not applicable.

Evaluation Findings

Currently, studies on the impact of managed care on cost, quality, and access with regard to the pilot in Mobile are under review by an external review entity.

Other Quantitative Data

Not applicable.

ALASKA

OVERVIEW

Alaska does not have a full-scale, at-risk managed behavioral health care program; behavioral health services remain in the fee-for-service system. However, the Division of Medical Assistance (DMA), within the Department of Health and Human Services (DHHS), is in contract negotiation phase for a prior authorization program covering inpatient and clinic-based mental health rehabilitation services. This contract was awarded to a peer review organization (PRO) in August 1997 but currently is suspended.

Managed Care Programs for Behavioral Health Services

MEDICAID WAIVERS

Not applicable.

MEDICAID VOLUNTARY

Not applicable.

OTHER MANAGED CARE PROGRAMS

Prior Authorization Program - mental health stand-alone: Medicaid program.

Geographic Location

Prior Authorization Program: Statewide.

Status of Programs

Prior Authorization Program: Prior authorization of outpatient mental health rehabilitation services remains suspended with plans to re-implement on November 1, 1998. The PRO is currently prior-authorizing inpatient care in psychiatric hospitals and residential psychiatric treatment centers.

Medicaid Substance Abuse Services Remaining Fee-For-Service

Crisis, opiate treatment (e.g., methadone maintenance therapy; only when chemical dependency is a secondary diagnosis), detoxification (e.g., acute and subacute), rehabilitation (e.g., assessment/diagnosis), outpatient.

Medicaid Mental Health Services Remaining Fee-For-Service

Inpatient, outpatient (e.g., partial hospitalization, clinic services), mental health support, rehabilitation (e.g., assessment/diagnosis), crisis, residential (e.g., residential psychiatric treatment facilities), Institution for Mental Diseases services (individuals age 65 and over, age 21 and under).

Medicaid Substance Abuse Services in Managed Care Plan

Prior Authorization Program: Not applicable.

Medicaid Mental Health Services in Managed Care Plan

Prior Authorization Program: Inpatient, rehabilitation.

Non-Medicaid Substance Abuse Services in Managed Care Plan

Not applicable.

Non-Medicaid Mental Health Services in Managed Care Plan

Not applicable.

Substance Abuse Prevention and Mental Health Promotion in Managed Care Plan

Prior Authorization Program: Not applicable.

Populations Covered Under Managed Behavioral Health

Prior Authorization Program: Not applicable.

State Managed Care Program Administration

Prior Authorization Program: DMA contracts with a PRO to conduct prior authorization functions. The PRO is responsible for training providers in prior authorization process and procedures, responding to requests from provider for prior authorization of services, and notifying provider and client of approval or denial and reconsideration of denial upon request.

Financing of Plans

Prior Authorization Program: The behavioral health managed care organization is paid a set fee for these services.

Coordination Between Primary and Behavioral Health Care

Not applicable.

Consumer-Family Involvement

Prior Authorization Program: Consumers and families were not involved in the design or drafting of the request for proposal (RFP), but the RFP was based on models from other states where consumers and families were involved in the design.

Future Plans

Prior Authorization Program: See Status of Programs Section.

★ *New Program Under Development:* The Alaska DMA is participating with other DHHS divisions in reviewing a concept for delivery of mental health services that is centered around a care coordinator function. Under this concept, a care coordinator would be paid to arrange for and purchase, or approve for purchase, services to meet the needs of clients. Care coordination would be a paid Medicaid service separate from treatment and evaluation services. This function would potentially apply to other State program services and Medicaid-funded services.

State Agency Administration

DHHS houses Medicaid, Mental Health, and Substance Abuse divisions. Medicaid falls under DMA; Mental Health under the Division of Mental Health and Developmental Disabilities; and Substance Abuse under the Division of Alcoholism and Drug Abuse.

Welfare Reform

Alaska has no welfare reform waiver applications pending or approved at this time. Under Alaska's Temporary Assistance for Needy Families (TANF) block grant, drug testing will not be mandatory for TANF beneficiaries, and beneficiaries who are convicted of drug felonies will not be denied coverage per se, but instead will be covered under a State program. This State program, Alaska Temporary Assistance Program, which uses only State funds, covers services needed to accomplish assigned activities and attain self-sufficiency. This program includes procedures (e.g., screenings) for referring clients to mental health and substance abuse providers.

Additionally, during Fall 1998, a demonstration project will begin in the Mat-Su Borough, a rural/suburban area of 22,909 square miles where about 60,000 Alaskans live. The project activities, involving collaboration among the nonprofit substance abuse treatment agency, the public assistance office, and the work search contractor, will provide screening, assessment, and treatment of temporary assistance clients. These services are in addition to the customary services such as case management and work search support. The policy goal of the project is to develop an effective collaborative model to assist clients with substance abuse problems and help them obtain and maintain employment. The experience of this project will be used to plan the replication of similar activities across the state.

County

Not applicable.

Evaluation Findings

Not applicable.

Other Quantitative Data

Not applicable.

ARIZONA

OVERVIEW

The Arizona Health Care Cost Containment System (AHCCCS) is Arizona's Medicaid program and the State's health care program for persons who do not qualify for Medicaid. AHCCCS has three components:

- An integrated system for individuals age 18–20 who do not have serious mental illness (SMI) or severe emotional disturbance (SED) (acute care health plans);
- A behavioral health "carve-out" (Regional Behavioral Health Authorities—RBHAs) for children age 17 and under, all SMI adults over age 18, and adults age 21 and older; and
- A carve-in, long-term care system (Arizona Long-Term Care System—ALTCS) that offers acute medical care services, institutional services, and home- and community-based services to the elderly and physically disabled population.

The majority of Medicaid managed care members are served in the acute care system.

In response to a Children's Behavioral Health Intergovernmental Agreement (IGA), five agencies with intersecting responsibilities for children have come together to form an interagency case management project in two counties. This project is part of a larger effort to improve the behavioral health care delivery system for children.

Managed Care Programs for Behavioral Health Services

MEDICAID WAIVERS

Section 1115 - AHCCCS: integrated and carve-out: Acute mental health and substance abuse services integrated for a non-SMI, non-SED population age 18–20; mental health and substance abuse services carved out for all other populations; long-term care services carved in for elderly or physically disabled population.

MEDICAID VOLUNTARY

Not applicable.

OTHER MANAGED CARE PROGRAMS

Section 1115 - AHCCCS:

RBHAs - carve-out: RBHAs, managed care entities, serve State-funded populations: SMI adults who are not Medicaid-eligible and non-Medicaid pregnant women who have substance abuse problems.

Interagency Case Management Project (ICMP)-integrated: Through an IGA between the Departments of Health Services, Economic Security, Education, Juvenile Corrections, and the Administrative Office of the Courts, a 5-year project has been developed and implemented to centralize and coordinate utilization of publicly administered services and funds for children involved in multiple public service agencies such as child welfare, behavioral health, education, and/or the juvenile justice system. This project is part of a larger effort to improve the behavioral health care delivery system for children through the Children's Behavioral Health IGA.

Geographic Location

Section 1115 - AHCCCS:

Acute care health plans (for individuals age 18–20 non-SMI, non-SED): Statewide.

RBHAs (carve-out): Statewide.

ALTCS (long-term care): Statewide.

ICMP: One urban county (Maricopa); one rural county (Mojave).

Status of Programs

Section 1115 - AHCCCS:

Acute care health plans (for non-SMI, non-SED individuals age 18–20): Approved July 13, 1982; implemented October 1982 for acute medical care (included 72 hours of psychiatric emergency inpatient care per episode, a mandatory Medicaid service); April 1991: Non-SED children; October 1991: individuals age 18–20 (SMI and non-SMI); October 1995: Non-SMI adults age 21 and older enrolled in acute care program; October 1997: Received a 1-year extension to continue program. July 22, 1997.

RBHAs (carve-out): Implemented October 1990: SED children; October 1991: Individuals age 18–20 (SMI and non-SMI); November 1992: SMI adults age 21 and older. Governor Symington issued an executive order that the State Department of Health Services either operate as Maricopa County's RBHA or award a contract. March 1998: Request for proposal (RFP) for Maricopa County Regional Service Area RBHA released.

ALTCS (long-term care): Implemented December 19, 1988, for the developmentally disabled population; implemented on January 1, 1989, for the elderly or physically disabled.

ICMP: The IGA establishing the Maricopa ICMP was signed December 20, 1995. The project began taking its first cases in February 1996. The IGA establishing the Mohave ICMP was signed on April 25, 1996. The project began taking its first cases in June 1996.

Medicaid Substance Abuse Services Remaining Fee-For-Service

The Arizona Medicaid program no longer has a fee-for-service component.

Medicaid Mental Health Services Remaining Fee-For-Service

The Arizona Medicaid program no longer has a fee-for-service component.

Medicaid Substance Abuse Services in Managed Care Plan

Section 1115 - AHCCCS:

Acute care health plans (for non-SMI, non-SED individuals age 18–20): Inpatient detoxification (e.g., up to 4 days or more based on medical need); opiate treatment; outpatient; inpatient (e.g., counseling, case management).

RBHAs (carve-out): For adults: Unknown. For children: Unknown.

ALTCS (long-term care): ALTCS provides institutional care in either a Medicare/Medicaid-approved nursing facility or hospice or in an intermediate care facility for the mentally retarded (ICF/MR), if the member requires the level of care in these facilities.

Medicaid Mental Health Services in Managed Care Plan

Section 1115 - AHCCCS:

Acute care health plans (for non-SMI, non-SED individuals, age 18–20): Inpatient (Institution for Mental Diseases (IMD) for individuals under age 21 and over age 65; general acute care hospital, psychiatric facilities/hospitals); outpatient (e.g., clinic services, laboratory and radiology services for medication regulation and diagnosis, screening, evaluation and diagnosis, nonphysician providers, psychotropic medication adjustment and monitoring); support (e.g., children's intensive case management, SMI clinical case management, case management, behavior management, individual therapy and counseling, group and/or family therapy and counseling; partial care, basic and intensive in-home services); crisis (e.g., 24-hour, emergency); rehabilitation (e.g., psychosocial); pharmacy (psychotropic medications).

RBHAs (carve-out): For adults: Unknown. For children: Unknown. Differential coverage is provided for children with SED. Based on the Arizona Level of Functional Assessment Guide, intensive case management is assigned to children with high needs, thereby linked to SED. Children with lower needs are case coordinated. Comprehensive mental health services are available to either population.

ALTCS (long-term care): Support (e.g., partial care, individual therapy and counseling, group and/or family therapy and counseling); inpatient (hospital services, psychiatric facility for individuals under age 21; IMD for individuals over age 65); residential; pharmacy (e.g., psychotropic medications); crisis (e.g., emergency services); outpatient (e.g., evaluation and diagnosis, screening).

Non-Medicaid Substance Abuse Services in Managed Care Plan

Section 1115 - AHCCCS:

RBHAs (carve-out): Maximum 72-hour emergency care.

ICMP: ICMP children who are assessed to have a need for substance abuse treatment may be enrolled with the RBHA (if not already enrolled) and will receive medically necessary services, targeted to address the substance abuse problem. These services are funded through the RBHA and provided according to the same criteria followed by the RBHA for non-ICMP Medicaid and non-Medicaid children. Depending on their involvement with other child-serving systems, ICMP children may also receive substance abuse services through other child-serving systems (e.g., the juvenile court system).

Non-Medicaid Mental Health Services in Managed Care Plan

Section 1115 - AHCCCS:

RBHAs (carve-out): Maximum 72-hour emergency care.

ICMP: ICMP children who are assessed to have a need for mental health treatment may be enrolled with the RBHA (if not already enrolled) and will receive all covered and medically necessary services, targeted to address the mental health problem. These services are funded through the RBHA and provided according to the same criteria followed by the RBHA for non-ICMP Medicaid and non-Medicaid children. Depending on their involvement with other child-serving systems, ICMP children may also receive mental health services through other child-serving systems (e.g., the Department of Economic Security/Administration for Children, Youth, and Families (DES/ACYF)).

Substance Abuse Prevention and Mental Health Promotion in Managed Care Plan

Section 1115 - AHCCCS:

Acute health plans (for non-SMI, non-SED individuals age 18–20): Managed care organizations (MCOs) are expected to provide the following prevention services: Life skills, community development, environmental strategies, public awareness, parent education, mentoring, and peer leadership. Community development and community organizing around prevention issues are currently being promoted as a State mandate to be supported by MCOs.

RBHAs (carve-out): MCOs are expected to provide the following prevention services: Life skills, community development, environmental strategies, public awareness, parent education, mentoring, and peer leadership. Community development and community organizing around prevention issues are currently being promoted as a State mandate to be supported by MCOs.

ALTCS (long-term care): Unknown.

ICMP: Life skills, community development, environmental strategies, public awareness, parent education, mentoring, and peer leadership.

Populations Covered Under Managed Behavioral Health

Section 1115 - AHCCCS:

Acute care health plans (for non-SMI, non-SED individuals, age 18–20): Adults and children mandatory: Aid to Families with Dependent Children/Temporary Assistance for Needy Families (AFDC/TANF,) Seventh Omnibus Budget Reconciliation Act (SOBRA), Supplemental Security Income (SSI), SOBRA pregnant women and infants up to age 1 (up to 140 percent Federal poverty level (FPL)).

RBHAs (carve-out): Adults and children mandatory: AFDC/TANF, SOBRA, SSI, SOBRA pregnant women and infants up to age 1 (up to 140 percent FPL); the "State Only" groups, that is, Eligible Assistance Children, Medically Needy/Medically Indigent, Eligible Low Income Children, are eligible only for emergency inpatient behavioral health admission for up to 72 hours per episode, 12 days per contract year.

ALTCS (long-term care): AFDC/TANF; SSI. Individuals must be financially eligible to qualify for ALTCS. Nearly all ALTCS members meet financial eligibility requirements based on the established SSI criteria; a small number are determined eligible based on TANF criteria. Once financial eligibility has been established for ALTCS, a preadmission screen (PAS) is conducted by a registered nurse or social worker to determine if the individual is at risk of institutionalization in either a nursing facility or ICF/MR. The registered nurse or social worker can refer the case to a physician for a final determina-

tion. AHCCCS has developed two standardized PAS instruments, one to screen elderly and physically disabled persons and the other to screen developmentally disabled persons. The PAS instruments use weighted scores to provide information on the functional, medical, nursing, and social needs of an individual that are the basis for determining medical eligibility for ALTCS services.

ICMP: Children served by multiple agencies. In the Maricopa County project, about 89 percent of the children served are in foster care through DES/ACYF; about 64 percent are enrolled with the RBHA for behavioral health services; about 24 percent are on juvenile probation; about 13 percent are receiving services through Department of Economic Security/Division of Developmental Disabilities (DES/DDD) for a developmental disability; and about 11 percent are on juvenile parole.

In the Mohave County project, about 33 percent of the children served are in foster care through DES/ACYF; about 80 percent are enrolled with the RBHA for behavioral health services; about 50 percent are on juvenile probation; about 7 percent are receiving services through DES/DDD for a developmental disability; and about 18 percent are on juvenile parole.

Children are referred to the ICMP by caseworkers from the participating agencies: DES/ACYF, DES/DDD, RBHA, Juvenile Probation, or Juvenile Corrections. (The Mohave project also allows referrals from the school system.) Children referred to the project must be currently involved in at least two of the child-serving systems identified above. The Mohave project also accepts referrals of children who are not currently involved in multiple systems, but are at immediate risk of becoming involved with more than one agency. Children referred must also have multiple unmet needs (needs that have not been successfully met through the traditional service delivery system).

State Managed Care Program Administration

Section 1115 - AHCCCS:

Acute care health plans (for non-SMI, non-SED individuals, age 18–20): AHCCCS is Arizona's Medicaid agency. For non-SMI individuals age 18–20, AHCCCS contracts with 12 acute care prepaid health plans (11 nonprofit, 1 for-profit). These contracts are awarded by the Geographic Service Areas, of which there are nine.

RBHAs (carve-out): Arizona Department of Health Services (ADHS) is the State agency mandated by the legislature to provide behavioral health services. AHCCCS contracts with ADHS, Division of Behavioral Health Services (ADHS/DBHS) for the provision of Medicaid-covered behavioral health services. Specifically, for all individuals except 18–20-year-olds who do not have an SMI, ADHS/DBHS contracts with five RBHAs. Contracts are established with the RBHAs to provide the SMI services. RBHAs conduct planning, monitoring, and prior authorization for Arizona's behavioral health population. RBHAs are private, nonprofit corporations, established to administer public sector behavioral health services. Generally, RBHAs receive non-Medicaid funding according to established subvention formulae based on a number of indicators, including utilization information.

Some RBHAs manage other services, but most concentrate on behavioral health services only. Other than case management, most RBHAs do not deliver direct services, but instead contract with the actual providers of behavioral health services. Participating plans include physician-owned plans, hospital-owned plans, local county plans, and subsidiary plans of several MCOs. Each RBHA subcontracts with regional and out-of-region providers to ensure that a continuum of services is available within each geographic area served. Providers in urban counties may represent physician-owned organizations, hospital-owned organizations, local providers offering both inpatient and outpatient services, networks of outpatient providers, individual practitioners, laboratories, and case management agencies.

For children and adolescents, a network of behavioral health providers are contracted with jointly by four State agencies. This process, termed SPOC, or single purchase of care, allows the child welfare agency, juvenile justice courts, juvenile corrections system, and the behavioral health system's RBHAs to plan jointly and procure behavioral health services for individually and jointly administered populations.

ALTCS (long-term care): ALTCS services for the elderly or physically disabled population are delivered by a network of eight program contractors

located throughout the State. On October 1, 1996, AHCCCS awarded new contracts for up to a 5-year period, subject to annual renewal by AHCCCS. Program contractors provide services for ALTCS members in the same way that health plans provide acute care services to AHCCCS-enrolled members. Only one program contractor operates in each county, and members are enrolled with the program contractor in their county of residence. Once enrolled, the member has a choice of available primary care providers who coordinate care and act as gatekeepers.

By statute, ALTCS services for the developmentally disabled population are delivered by the DES/DDD under a capitation arrangement with AHCCCS. DES/DDD operates in the same manner as other program contractors and additionally administers a 100 percent State-funded program for developmentally disabled persons who are not eligible for ALTCS. Once enrolled with DES/DDD, a developmentally disabled member chooses a primary care provider, who coordinates the member's care.

ICMP: The ADHS/DBHS is designated as the lead agency. DBHS is responsible for administering the interagency coordinated program involving case managers, caseworkers, probation officers, and parole officers.

For both the Mohave and the Maricopa projects, children receiving services through the ICMP are potentially eligible to receive services from providers who contract with any of the child-serving agencies with which they are currently involved. For example, a child who was on probation, dependent, and enrolled in an RBHA would be potentially eligible to receive any of the services contracted for through the county juvenile probation department, the DES/ACYF district, and the responsible RBHA. The child would receive services provided through these systems based on each agency's criteria for provision of the service (e.g., for behavioral health the service needs to be medically necessary).

If a needed service is provided by an agency in which the child is not currently involved, the ICMP project facilitates the child's enrollment or referral to the system so that the needed service can be requested. For example, an ICMP child who is assessed to have a need for a psychiatric evaluation is enrolled with the RBHA so that the service can be acquired.

For the Maricopa ICMP, the primary agency players involved in the child and family's case are the members of the ICMP case management team. The team includes the family's ICMP case manager, an ICMP case manager aide, the ICMP supervisor, and the ICMP consulting/treating psychiatrist. The ICMP case manager is the primary link between the family, the child-serving agencies in which the family is involved, the health plan, the primary care provider, and the various providers from which the child or family members receive services.

For the Mohave ICMP, responsibility for coordination in a child's case is more generalized, and resides primarily with MAT team members. The County-Wide Coordinator (CWC) is responsible for coordination of MAT meetings, which bring all agencies involved in the case and the child's family together to discuss the case and develop a MAT service plan. The agency who initially referred the child to the project is designated the Lead Agency, and the MAT team representative from this agency leads the development of the MAT service plan. At the MAT meeting, responsibility for follow-through activities identified in the MAT service plan is assigned to MAT team agency representatives, as appropriate. The CWC is responsible for monitoring follow-through on the activities identified in the MAT plan and for arranging future MAT team meetings on the case as needed.

Financing of Plans

Section 1115 - AHCCCS:

Acute care health plans (for non-SMI, non-SED individuals, age 18–20): Medicaid finances the AHCCCS program. Health plans are paid an up-front or prospective monthly capitation amount for each member enrolled with the health plan. The capitation rate is based on a rate code (e.g., population category) and geographic area. The State hired an independent actuarial firm to develop rate ranges based on fee-for-service (FFS) experience provided by counties and an actuarial database. These rate ranges form the basis for capitation rates. Anticipated savings associated with managed care were built into the capitation rate. Savings and profits may be used to reinvest in administration of services and to build financial stability.

For each Medicaid dollar available to the acute care plans under AHCCCS, the State match is paid through a combination of general fund monies and a fixed contribution from each county.

RBHAs (carve-out): ADHS obtains block grants and legislative appropriations for behavioral health services, including non-Medicaid funds. These State funds are apportioned to the RBHAs under the terms of their contract with ADHS. Federal block grant funding is also available to RBHAs for treatment programs for pregnant women with substance abuse problems. Generally, RBHAs receive non-Medicaid funding according to established subvention formulae based on a number of indicators, including utilization information.

AHCCCS gives ADHS a capitation rate per member per month for the entire number of Title XIX-eligible individuals on AHCCCS. ADHS then pays the RBHAs according to their contracts (the process is between ADHS and the RBHAs, and AHCCCS is not involved). The RBHAs are at risk and receive a capitation rate for Medicaid covered services, as well as a budget allocation for block grant and State-only funds each month. Depending on the subcontract agreement, RBHAs may pass on risk to their subcontracted providers. Provider contracts are either capitated or paid on an FFS basis.

The capitation rate is based on a rate code (e.g., population category) and geographic area. The State hired an independent actuarial firm to develop rate ranges based on FFS experience provided by counties and an actuarial database. These rate ranges form the basis for capitation rates. Anticipated savings associated with managed care were built into the capitation rate. Savings and profits may be used to reinvest in administration of services and to build financial stability.

ALTCS (long-term care): ALTCS is funded by Federal, State, and county monies. Historically, the county contribution was established by the legislature, and the counties paid most of the State share for the ALTCS program. In November 1997 the State legislature froze the counties' contributions at State fiscal year 1997/1998 levels and required the State and counties to each pay 50 percent of any increase. State funding for the developmentally disabled population is included in the DES/DDD budget, and AHCCCS passes through the Federal funding to DES/DDD.

Parallel to the acute care program, AHCCCS pays program contractors prospectively on a capitated basis. ALTCS capitation rates are blended rates that include nursing facility costs, home- and community-based services, acute medical care services, behavioral health services, and case management services. Beginning October 1, 1997, the weighted average statewide capitation rate paid to program contractors for covered services provided to the elderly or physically disabled population is $2,192 per member per month. The weighted average for the developmentally disabled population is $2,082. The rates are based on AHCCCS FFS rates, program contractor financial statements, service utilization data, and historical trends. In a contract year, this information is used to determine the capitation rate ranges; in renewal years, this information is used to adjust rates. All ALTCS-eligible individuals are required to contribute a share of the cost for institutional care. This share is generally calculated by subtracting certain allowable deductions from the individual's income.

ICMP: The Mohave and Maricopa ICMP projects are 5-year pilot projects funded by the ADES; the Administrative Office of the Arizona Supreme Court (AOC); ADHS/DBHS; and the Arizona Department of Juvenile Corrections (ADJC). Agencies share annual operations, equipment, and program evaluation costs for the ICMP case management site in Maricopa County and for the CWC and associated costs in Mohave County. Each fiscal year, DES, AOC, and ADJC transfer their annual share of funds for the project to ADHS/DBHS. DBHS transfers these funds to the RBHA responsible for the financial management of each project. The RBHAs contribute the BHS share of funds for the projects.

The ICMP project does not use blended funding to purchase services for ICMP clients. Services provided to ICMP children are authorized and paid for by the traditional children's service delivery systems, in the same way that services are authorized and paid for non-ICMP children. Because the ICMP projects currently link clients with services using the traditional service delivery systems, the risk and method of provider payment remains the same for ICMP and non-ICMP clients.

Coordination Between Primary and Behavioral Health Care

Section 1115 - AHCCCS:

Acute care health plans (for non-SMI, non-SED individuals, age 18–20): A contract between ADHS and AHCCCS provides the important first step in the partnering process. It ensures collaboration and coordination of the administration and management of both agencies to effectively administer the managed behavioral health care program for Medicaid recipients. The medical directors of both agencies routinely collaborate on the development of policy directives for health plans and RBHAs. Meetings are held at least quarterly and primarily focus on member-level coordination of care issues. In addition to developing and reviewing medical criteria such as treatment guidelines and placement criteria, attendees exchange information about health plans and RBHA systems.

RBHAs (carve-out): RBHAs are required to link with members' health plans to obtain needed medical information and to advise the primary care physicians regarding the member's mental health treatment. Regular, ongoing meetings occur between health plan representatives and RBHA directors to ensure that the coordination is occurring. The health plan is the medical care home base. The health plan may refer members to RBHAs, but the member may also self-refer. All individuals who qualify for Title XIX Medicaid in Arizona are eligible for the behavioral health carve-out (with the exception of non-SMI individuals age 18–20, who are enrolled in health plans) because the behavioral health services are part of the AHCCCS service package.

ALTCS (long-term care): Acute medical care services provided to ALTCS members are the same as those provided in the acute care program. Each ALTCS member is assigned a case manager by the program contractor. The case manager coordinates care with the primary care provider and is responsible for identifying, planning, obtaining, and monitoring appropriate services that meet the member's needs.

ICMP: Coordination of care between the RBHA and the health plan/primary care provider for RBHA-enrolled, ICMP children is carried out in the same manner as it is for RBHA-enrolled non-ICMP children. The ICMP case manager is required to perform the same coordination functions with health plans and primary care providers, using the same procedures that RBHA case managers follow.

Consumer-Family Involvement

Section 1115 - AHCCCS:

Acute care health plans (for non-SMI, non-SED individuals, age 18–20): Unknown.

RBHAs (carve-out): Advocates Coming Together (ACT), a group of consumers, family members, advocates, and other stakeholders in the behavioral health system, developed recommendations concerning system redesign in Maricopa County. ACT produced "Managed Care Vision, Values, and Principles" and RFP recommendations from the consumer perspective. Recommendations were presented to the RFP development committee and considered in the final design. Queries and responses regarding this process were also addressed in the bidder's conference, follow-up technical response bulletins, and RFP amendment.

ALTCS (long-term care): Unknown.

ICMP: Families were involved in the development of the ICMP projects through representation on the Children's IGA Executive Committee, the ICMP Case Management Work Group, and the Mohave Planning and Oversight Committee when these committees were engaged in the planning phase for the projects.

Future Plans

Section 1115: AHCCCS:

Acute care health plans (for non-SMI, non-SED individuals, age 18–20): Currently, AHCCCS is working to have its State plan amendment approved by the Health Care Financing Administration for the Title XXI, State Children's Health Insurance Plan for medical and mental health services to Arizona's uninsured under-19 population meeting 150 percent FPL.

RBHAs (carve-out): Governor Hull recently proposed a plan to include $7 million in supplemental funding for the SMI population in Maricopa County. Additionally, the new contractor chosen to become the RBHA for Maricopa County (Phoenix) will begin its 3-year contract August 1, 1998. The State released its RFP March 31, 1998.

ALTCS (long-term care): Effective October 1, 2000, the statutory requirement was deleted which mandated that the two largest Arizona counties must be program contractors and that three other counties be given the right of first refusal to be a program contractor. As the law is now written, all of Arizona's 15 counties will be required to competitively bid if they want to participate as program contractors for their respective counties. The ALTCS RFP that goes out to bid in 2000 will represent the first time that competitive bids will be accepted for all counties and the first time that the previously mandated counties will be required to compete with other program contractors to provide ALTCS services in their respective counties.

ICMP: A comprehensive evaluation is currently being conducted on the Maricopa ICMP project, with final evaluation results due in the year 2001. Interim and final evaluation results are likely to be significant factors in determining whether the project will be continued past its 5-year pilot period. There continues to be substantial interest in expanding the ICMP so that more multiagency children and their families can be served through the project. The possibility of expansion continues to be explored.

State Agency Administration

ADHS houses DBHS (Mental Health) and Office of Substance Abuse and General Mental Health Services (Substance Abuse). The Medicaid agency, AHCCCS, is a separate State agency.

Welfare Reform

Under Arizona's welfare reform plan, drug testing is not mandatory for TANF eligibles; however, a TANF-eligible individual who is convicted of a drug felony will be denied benefits.

County

ADHS/DBHS released an RFP seeking a contractor for the development, management, and delivery of covered services in Maricopa County.

Evaluation Findings

Section 1115 - AHCCCS: Independent quality audits have been performed periodically.

Other Quantitative Data

As of July 1998, AHCCCS provided acute care, behavioral health, and long-term care services to 431,047 eligible members (approximately 10 percent of Arizona's population).

ARKANSAS

OVERVIEW

The Department of Human Services (DHS) recently released a request for proposals (RFP) for a behavioral health managed care program for individuals under age 21. Other than this program, behavioral health services are not included under the rubric of managed care.

The program, known as Benefit Arkansas, is funded through a combination of Medicaid, Title IV-E, and State general revenue (SGR) dollars. Mental health services are included, but substance abuse services are included only for the dually diagnosed.

Managed Care Programs for Behavioral Health Services

MEDICAID WAIVERS

Section 1915(b) - Benefit Arkansas - mental health stand-alone: Mental health services for children and adolescents under age 21; substance abuse services provided only to dually diagnosed.

MEDICAID VOLUNTARY

Not applicable.

OTHER MANAGED CARE PROGRAMS

Not applicable.

Geographic Location

Section 1915(b) - Benefit Arkansas: Statewide; divided into five regions.

Status of Programs

Section 1915(b) - Benefit Arkansas: Submitted May 1, 1998; currently under Health Care Financing Administration review; implementation expected October 1, 1998. Effective until June 30, 1999.

Medicaid Substance Abuse Services Remaining Fee-For-Service

Arkansas does not recognize "substance abuse" as a Medicaid-covered service. Arkansas does treat the effects of substance abuse, but not as a rehabilitative service.

Medicaid Mental Health Services Remaining Fee-For-Service

The following mental health services are covered under the Arkansas Medicaid program: inpatient, outpatient, rehabilitation, Institution for Mental Diseases services for individuals under age 21.

Medicaid Substance Abuse Services in Managed Care Plan

Section 1915(b) - Benefit Arkansas: Substance abuse services for dually diagnosed individuals only include acute and subacute detoxification (e.g., medical, observation); residential; outpatient (e.g., structured addiction programs, diagnostic evaluation, medication visits, counseling); inpatient services.

Medicaid Mental Health Services in Managed Care Plan

Section 1915(b) - Benefit Arkansas: Inpatient, outpatient (e.g., observation/holding beds, partial hospitalization); crisis (e.g., stabilization, emergency shelters, community-based crisis intervention); residential (e.g., 24-hour treatment, stabilization); mental health support (e.g., case management, mental health rehabilitation).

Non-Medicaid Substance Abuse Services in Managed Care Plan

Not applicable.

Non-Medicaid Mental Health Services in Managed Care Plan

Not applicable.

Substance Abuse Prevention and Mental Health Promotion in Managed Care Plan

Section 1915(b) - Benefit Arkansas: Early and periodic screening, diagnosis, and treatment. The RFP states that the program must promote early identification of mental, emotional, or behavioral disorders; provide early intervention with appropriate mental health services and supports to children and families; and encourage activities that identify and ameliorate environmental factors that put children at risk for developmental, emotional, or behavioral problems.

Populations Covered Under Managed Behavioral Health

Section 1915(b) - Benefit Arkansas: Mandatory children and adolescents: Aid to Families with Dependent Children/Temporary Assistance for Needy Families individuals under age 21 and children in custody of the Division of Child and Family Services.

State Managed Care Program Administration

Section 1915(b) - Benefit Arkansas: DHS plans to contract with Arkansas Behavioral Care, LLC (ABC). ABC comprises a private, for-profit behavioral health managed care organization (BHMCO) and Summit, LLC, a limited liability corporation formed by the Mental Health Centers of Arkansas (State community mental health centers (CMHCs)). The BHMCO is the majority stakeholder, although the Board of ABC has representation from Summit. ABC will contract with individual mental health centers separately for services as well as non-CMHC providers under the State's any-willing-provider rules.

For those dually diagnosed, the primary diagnosis will determine the lead agency responsible for the child.

Financing of Plans

Section 1915(b) - Benefit Arkansas: This program will be financed primarily through Medicaid and Title IV-E and some SGR funds. ABC is capitated and at full risk. Nine capitation rates have been established: three different age ranges for children on Medicaid not in custody; three rates for children in custody of the State, utilizing Medicaid, Title IV-E, and SGR; and three rates for children currently in a 1115 waiver, under the age of 19, who will be included as a covered target population on January 1, 1999. This last group (ARKids First) represents a population between 100 percent and 200 percent of Federal poverty level (FPL).

Medicaid capitation can pay for services for non-custody DHS children if funds for them have been exhausted. The capitation rates are fixed by the Division. ABC can pass down or share risk through subcapitation or case rates with its subcontractors. Alternatively, ABC can reimburse its subcontractors on a fee-for-service basis.

An actuarial firm was hired by DHS to calculate mental health capitation rates for the program, and the current Medicaid funding stream was used to construct the capitation rates. They are calculated at 93.8 percent upper payment limit; the 6.2 percent reduction covers the costs to the State for program administration and monitoring. Included within the actuarial computations were the monies used to pay for services where there was dual diagnosis; therefore, no new funding stream was included for dually diagnosed individuals. There is no incentive to generate savings; the administrative rate has been set with a withhold that can be earned back through acceptable performance. All funds not spent on consumer services as allocated will be spent on system improvements benefiting consumers in the following year.

Coordination Between Primary and Behavioral Health Care

Section 1915(b) - Benefit Arkansas: The program integrates services and supports for children and youth with mental, emotional, or behavioral disorders by using, promoting, or creating coherent policy around planning, evaluation, programmatic, and financial linkages among agencies with responsibility for children and youth.

Consumer-Family Involvement

Section 1915(b) - Benefit Arkansas: Families and consumers are involved as full participants in all aspects of the planning, delivery, and evaluation of managed behavioral health care services.

Future Plans

Section 1915(b) - Benefit Arkansas: Under the new Children's Health Insurance Program (CHIP), ARKids First (200 percent FPL) up to age 18 will be included by January 1, 1999. Substance abuse treatment may be added at a later date to this waiver; if this occurs, capitation rates will be adjusted accordingly.

★ *New Program Under Development:* The University of Arkansas for Medical Science has developed the prototype model for the treatment of addicted women with families. The Bureau of Alcohol and Drug Abuse Prevention will be responsible for the development of the 1915(b) Medicaid waiver. This waiver is incomplete at this time.

State Agency Administration

The Division of Mental Health Services and the Division of Medical Services (Medicaid) are under the DHS. The Bureau of Alcohol and Drug Abuse Prevention is under the Department of Health.

Welfare Reform

Currently, under the Arkansas welfare reform plan, Temporary Assistance for Needy Families (TANF) will be denied to those convicted of felonies involving the manufacture or distribution of drugs. However, the State plan names substance abuse treatment as a supportive service. Clients who have felony convictions and are not eligible to receive substance abuse services under TANF will be provided services through the Substance Abuse Prevention and Treatment (SAPT) block grant.

At this time, the Arkansas Department of Health, Bureau of Alcohol and Drug Abuse Prevention, is working with other agencies to develop a curriculum to train caseworkers to screen, identify, and refer individuals who need substance abuse services. Because of a waiting list of approximately 400 clients per day seeking substance abuse services, the Bureau is currently negotiating with DHS, Division of County Operations, to secure additional funding from TANF savings. Substance abuse services will be expanded to provide timely treatment to TANF recipients.

County

Not applicable.

Evaluation Findings

Section 1915(b) - Benefit Arkansas: The RFP indicated a number of performance indicators with which the managed care organization will comply.

Other Quantitative Data

Not applicable.

CALIFORNIA

OVERVIEW

As managed behavioral health care evolves in California, two separate managed care systems—one for mental health and one for substance abuse—are being developed and implemented.

California has implemented its Medi-Cal managed care initiatives primarily on the county level. Counties serve as the local mental health plan manager (MHP). As the plan managers, counties are responsible for authorizing and paying for all publicly funded mental health services. The Department of Mental Health (DMH) has played a key role in assigning counties such responsibility.

Most recently, DMH began implementing a 1915(b) waiver for Medi-Cal Specialty Mental Health Services (inpatient and outpatient) Consolidation. This is the second phase of mental health services consolidation at the county level. In 1995, inpatient hospital services and State-funded mental health services were realigned at the county level. The newest waiver completes the consolidation of Medi-Cal mental health funding at the county level. It subsumes the previous waiver for inpatient psychiatric hospital services and incorporates mental health services that previously were included in the Department of Health Services' managed care programs for physical health. After successful implementation of the Medi-Cal Specialty Mental Health Services Consolidation program, California's next step will be to establish the program under a capitated or other full-risk model.

In addition, two separate managed mental health field tests are currently operating in California counties to test various concepts as the State moves toward capitation (see County Section for a full description).

Substance abuse is excluded from all California waivers and is reimbursed on a fee-for-service (FFS) basis. There is currently a major statewide planning effort, however, to create an outcome-based managed system of care in the substance abuse field that is unique to California's needs.

Managed Care Programs for Behavioral Health Services

MEDICAID WAIVERS

Section 1915(b) - Medi-Cal Specialty Mental Health Services Consolidation - mental health stand-alone: Inpatient and outpatient mental health services are consolidated at the county level.
Section 1915(b) - Two-Plan Model - integrated: Physical health waiver includes substance abuse services in 12 counties.

MEDICAID VOLUNTARY

Not applicable.

OTHER MANAGED CARE PROGRAMS

Short-Doyle Program - mental health stand-alone: State-funded program that provides reimbursement for county mental health services to Medi-Cal-eligible and indigent individuals.

Geographic Location

Section 1915(b) - Medi-Cal Specialty Mental Health Services Consolidation: Statewide (except Solano and San Mateo County Field Tests—see County Section).

Section 1915(b) - Two-Plan Model: 12 counties (Alameda, Contra Costa, Fresno, Kern, Los Angeles, Riverside, San Bernardino, San Francisco, San Joaquin, Santa Clara, Stanislaus, Tulare).

Short-Doyle Program: Same as Medi-Cal Specialty Mental Health Services Consolidation program.

Status of Programs

Section 1915(b) - Medi-Cal Specialty Mental Health Services Consolidation: Submitted to the Health Care Financing Administration August 7, 1997. Approved as renewal of original Medicaid psychiatric inpatient hospital services consolidation waiver September 5, 1997 (this waiver was first implemented in March 1995). Fully implemented in 56 counties by July 1, 1998. Implementation schedule:

- November 1, 1997 - 5 counties
- January 1, 1998 - 10 counties
- April 1, 1998 - 32 counties
- June 1, 1998 - 8 counties
- July 1, 1998 - 1 county

Section 1915(b) - Two-Plan Model: Implemented January 22, 1996.

Short-Doyle Program: Same as Medi-Cal Specialty Mental Health Services Consolidation program.

Medicaid Substance Abuse Services Remaining Fee-For-Service

Opiate treatment program (e.g., narcotic); outpatient drug-free services (e.g., naltrexone treatment services); rehabilitative (e.g., day care rehabilitative treatment services); residential (e.g., perinatal substance abuse services).

Medicaid Mental Health Services Remaining Fee-For-Service

Inpatient; outpatient (e.g., direct services by licensed clinical social workers and marriage, family, and child counselors for children only, physician services, psychologist services limited to two per month for adults, clinic services); pharmacy; rehabilitation (Rehab Option, offered only through the Short-Doyle/Medi-Cal program); support (e.g., targeted case management).

Medicaid Substance Abuse Services in Managed Care Plan

Section 1915(b) - Medi-Cal Specialty Mental Health Services Consolidation: Not applicable.

Section 1915(b) - Two-Plan Model: Unknown.

Medicaid Mental Health Services in Managed Care Plan

Section 1915(b) - Medi-Cal Specialty Mental Health Services Consolidation: Inpatient; outpatient; crisis (e.g., emergency services); mental health support (e.g., case management, medication support); residential; rehabilitation (e.g., day treatment).

Section 1915(b) - Two-Plan Model: Not applicable.

Non-Medicaid Substance Abuse Services in Managed Care Plan

Short-Doyle Program: Not applicable.

Non-Medicaid Mental Health Services in Managed Care Plan

Short-Doyle Program: Rehabilitation (e.g., day treatment); inpatient (e.g., psychiatric hospital); support (e.g., targeted case management); residential (e.g., adult, crisis).

Substance Abuse Prevention and Mental Health Promotion in Managed Care Plan

Section 1915(b) - Medi-Cal Specialty Mental Health Services Consolidation: None.

Section 1915(b) - Two-Plan Model: Unknown.

Short-Doyle Program: Same as Medi-Cal Specialty Mental Health Services Consolidation program.

Populations Covered Under Managed Behavioral Health

Section 1915(b) - Medi-Cal Specialty Mental Health Services Consolidation: Mandatory adults and children: Aid to Families with Dependent Children/Temporary Assistance for Needy Families (AFDC/TANF); Supplemental Security Income (SSI); dually diagnosed.

Section 1915(b) - Two-Plan Model: Unknown.

Short-Doyle Program - Mandatory adults and children: AFDC/TANF; SSI; uninsured, underinsured.

State Managed Care Program Administration

Section 1915(b) - Medi-Cal Specialty Mental Health Services Consolidation: This program is administered by DMH through an interagency agreement with the Department of Health Services, the single State

Medicaid agency. DMH formally contracts with MHPs for service delivery. The county mental health department has the first right of refusal to serve as the MHP. Currently, all MHPs are county mental health departments. County MHPs are the designated point of responsibility for the delivery of specialty mental health services (psychiatric inpatient hospital services; licensed clinical social worker and marriage, family, and child counselor services; and targeted case management) to treat most mental health diagnoses. The program does not cover treatment of diagnoses such as substance abuse disorders, cognitive disorders, mental retardation, and antipersonality disorder, although the mental health treatment for individuals with dual diagnoses will be covered by the MHPs (see County Section for more detail). MHP provider networks include organizational providers previously contracting with the MHP and individual and group practitioners (psychiatrists, psychologists, LCSWs, MFCCs, RNs with master's degrees).

DMH is responsible for monitoring and oversight to ensure that services comply with all Federal and State requirements. DMH requires local MHPs and providers to establish and use systems to review the quality and appropriateness of services funded by Medi-Cal and audits for compliance with Medi-Cal requirements.

Section 1915(b) - Two-Plan Model: The State contracts with one private, for-profit managed care organization and one local initiative (LI) plan—a quasi-public agency—in each of the 12 counties except Fresno County, which has two commercial plans because the LI was unqualified. These two entities compete for the county's Medi-Cal recipients.

Short-Doyle Program: Same as Medi-Cal Specialty Mental Health Services Consolidation program.

Financing of Plans

Section 1915(b) - Medi-Cal Specialty Mental Health Services Consolidation: This program operates as a managed FFS system. It is funded through Medicaid and State general funds. For State mental health dollars, one-half of 1 percent of State sales tax is directly allocated to the counties for exclusive use. State sales tax goes directly to counties. There is also an allocation for Medi-Cal specialty mental health services.

MHPs also claim Federal financial participation (FFP) on an FFS basis for Medi-Cal services. Provider contracts with MHPs are primarily on a per diem basis. MHPs claim FFP on an FFS basis. Payment to provider is made with a variety of funding sources, including sales tax revenues, State General Fund allocation, FFP, and other sources. Funding is blended but also tracked separately for cost reporting purposes.

Section 1915(b) - Two-Plan Model: This program is funded by Medicaid dollars. The two plans are fully capitated and at risk. Capitation rates are set using a two-step process. First, an overall limit on program expenditures is calculated in order to comply with the requirement of the 1915(b) waiver that expenditures not exceed expected FFS expenditures for the enrolled population. For each county included in the pilot, capitation rates are developed. These rates are based on Medi-Cal managed care experience in one county, Santa Barbara, which has a particularly well-established, well-managed, and well-documented county-operated system.

Short-Doyle Program: Same as Medi-Cal Specialty Mental Health Services Consolidation program.

Coordination Between Primary and Behavioral Health Care

Section 1915(b) - Medi-Cal Specialty Mental Health Services Consolidation: Primary care providers are expected to continue to provide primary mental health services and receive support from county MHPs in the form of clinical consultation on issues such as appropriate medications and medication monitoring. County MHPs and Medi-Cal managed care plans are required to have formal memoranda of understanding covering referrals, clinical consultation, appropriate exchange of medical information, and dispute resolution. The county MHPs are required to establish protocols for coordination of care with FFS providers.

Section 1915(b) - Two-Plan Model: Unknown.

Short-Doyle Program: Same as Medi-Cal Specialty Mental Health Services Consolidation program.

Consumer-Family Involvement

Section 1915(b) - Medi-Cal Specialty Mental Health Services Consolidation: Consumers and families had extensive involvement in the planning process on various State and local committees. Also, they were

involved in State oversight monitoring of county plans.

Section 1915(b) - Two-Plan Model: Unknown.

Short-Doyle Program: Same as Medi-Cal Specialty Mental Health Services Consolidation program.

A Managed Mental Healthcare Steering Committee, with broad representation from the State mental health and Medicaid agencies, the California Mental Health Directors Association, consumers, the California Mental Health Planning Council, and other stakeholders, was established when the State first began planning managed mental health care in 1991. Authority for consumer/family membership on the Steering Committee is in State legislation (Welfare Institutions Code Section 14683). Members advised the DMH regarding the development and implementation of managed care for mental health and assisted in the resolution of the following issues: coordination of physical health and mental health care, access criteria for mental health services, minimum service array, quality improvement and performance outcome measures, client satisfaction, client and provider grievance procedures, children's issues, older adult issues, cultural competency and linguistic accessibility, management information systems, and financial terms of participation.

Future Plans

Section 1915(b) - Medi-Cal Specialty Mental Health Services Consolidation: In the future, the State expects to move to a fully capitated payment system for MHPs, which will constitute the final phase of mental health managed care implementation. There is currently no target date for implementation of a fully capitated payment system.

Section 1915(b) - Two-Plan Model: Unknown.

Short-Doyle Program: Same as Medi-Cal Specialty Mental Health Services Consolidation program.

★ *New Program Under Development:* Alcohol and Other Drugs (AOD) System of Care: The Department of Alcohol and Drug Programs (ADP) has proposed a framework for the redesign of the substance abuse services delivery system to create an outcome-based system of care that focuses on each client's individual needs and provides improved data and accountability. The design came from several years of study by the Department's Managed Care Policy Advisory Committee (MCPAC), which made several recommendations to improve the effectiveness and efficiency of substance abuse prevention and treatment systems. In particular, the committee's recommendations were to "unbundle" the rate structure, implement a data collection phase (based on a single client-based billing system), and then consider financing options. Other recommendations included adopting a standardized assessment tool to determine client level of functioning, using American Society of Addiction Medicine levels of care, and collecting outcome data for clients.

The fundamental principles of the MCPAC include the acknowledgment and maintenance of the distinct, diverse, and specialized substance abuse treatment and recovery services network.

This proposed redesign continues the existing concept of local control of substance abuse program services. Counties, as brokers of services, will develop and provide a continuum of services based on the assessed needs of the county population and available resources. The redesign and automation of the statewide substance abuse prevention, treatment, and recovery system will improve the State's ability to describe substance abuse services, costs, and client outcomes. The proposed system will provide better data at all levels. Information gaps in the current system will be closed by linking the fiscal and program data together in client records, including demographic data, services, and expenditures at the State, county, and provider levels. Proposed assessment and placement/discharge processes will allow evaluation of a client's progress with measurable levels of functioning at entry, during treatment, at exit, and following exit from services. Uniform services definitions and standards of care will align services provided with different funding sources.

The Department of ADP is identifying changes and developing new systems with input from an advisory group of field representatives and stakeholders. The system of care continues the existing concept of local control of the substance abuse prevention, treatment, and recovery network. Counties, as brokers, will develop and administer the provision of services based on the assessed needs of the population and available resources.

State Agency Administration

Medicaid (called Medi-Cal in California), mental health, and substance abuse are administered by separate departments within the Health and Welfare Agency. The Medi-Cal program is administered by DHS, the mental health program is administered by the DMH, and all substance abuse programs, including the Drug Medi-Cal Program, are administered by the Department of ADP.

Welfare Reform

- California submitted its Welfare-to-Work (WtW) grant on March 4, 1998. The grant will be administered by the Employment Development Department. One hundred percent of state funds will serve as the matching funds. Fifteen percent of the State project funds will be used as grants to State and local, public and private entities that will assist long-term TANF recipients entering unsubsidized employment. Special consideration will be given to proposals from rural areas, proposals that demonstrate leveraging of other resources, and proposals that demonstrate a coordinated approach to services. The substate allocation formula for 85 percent of the funds is as follows: 55 percent poor, 35 percent TANF, and 15 percent unemployed. Coordination mechanisms linking local WtW entities and local TANF agencies are required as part of local plans. Performance goals or outcome measures include a minimum of 45 percent of participants placed in unsubsidized jobs; a minimum of 70 percent of participants placed in unsubsidized employment after 6 months; and an average wage increase of 10 percent over the average wage placement for participants who remain employed for 6 months. Local targeting strategies will be developed by private industry councils in coordination with county welfare departments and other local WtW preparation partners. State targeting strategies for the Governor's 15 percent fund may include those with special barriers (e.g., homeless, individuals with mental illness, substance abusers).

- Welfare reform, like managed mental health care, is being implemented at the county level. Many counties in California are implementing welfare reform in different ways. On August 11, 1997, California enacted AB 1542, the Welfare-to-Work Act of 1997. This act renames the Federal TANF program the "California Work Opportunity and Responsibility to Kids" (CalWORKs) program. CalWORKS requires each county to submit a county plan to the State Department of Social Services. The county plans must include the provision of alcohol and drug services to recipients whose substance abuse creates a barrier to employment. A participant who is in a job search component of the county's WtW program (formally called the Greater Avenues for Independence (GAIN) program) may be directed to an assessment by the job search manager if the county believes the participant's substance abuse may limit or preclude his or her satisfactory completion of a job search. If the case manager believes that substance abuse will impair the participant's ability to obtain and retain employment, he or she must be referred to the county substance abuse program for an evaluation to determine if treatment is necessary. In such a case, the participant's WtW plan may include assignment to a treatment program.

  For example, Los Angeles County's new welfare system, CalWORKS, went into effect on April 1, 1998. More than $400 billion is earmarked for WtW and administrative services. Twenty million dollars is provided for mental health services and $40 million for substance abuse services. Comprehensive and integrated services, such as job training, mental health and substance abuse treatment, and skills employment, are provided to help people achieve gainful employment. Los Angeles County's system is predicated on moving poor families into jobs. The emphasis is on responsibility. New applicants must sign a contract promising to follow an individualized WtW plan. One of these WtW programs, GAIN, includes screening as one of its features. Applicants who report substance abuse or mental health problems are sent to an eligibility worker who has specialized training in these issues and will schedule a clinical assessment.

  Orange County implemented its new welfare program on February 17, 1998. An estimat-

ed $100 million of State and Federal funds are earmarked for welfare reform. Orange County, along with San Diego County, is opting for an aggressive privatization effort. The county will most likely contract with one of the nationally known welfare contractors who already work for the county.

Ventura County began implementing its welfare reform program in January 1998. Employees work in teams in seven one-stop career centers that were created across the county. Each team serves 1,000 to 1,500 families.

A major investment in staff development and training has been under way in Sacramento county with support from the Annie E. Casey Foundation. In 1993, the Department of Health and Human Services enacted an initiative to incorporate substance abuse services as an integral part of its service delivery systems. The program has three components: three levels of training to develop the ability of social workers, public health nurses, eligibility workers, and neighborhood-based service staff to provide treatment services to substance-abusing clients; the expansion of department and community resources, including the development of an automated service requisition and client tracking system; and program evaluation including both short- and long-term outcomes related to family functioning (reduction in Child Protective Services referrals and success in completion of either voluntary or court-ordered treatment plans).

County

Section 1915(b) - Medi-Cal Specialty Mental Health Services Consolidation: With the implementation of the consolidation waiver, counties are responsible for authorizing publicly funded inpatient and outpatient mental health services. Currently, all MHPs are county mental health departments, although if a county elects not to participate in the program, another entity may be the MHP. In addition to psychiatric inpatient hospital services, the county mental health departments have also historically been responsible for Short-Doyle/Medi-Cal (SD/MC) services, either by directly providing services or through subcontracting. Counties are implementing this waiver differently; most are administering the programs themselves, rather than contracting with administrative services organizations, with the exception of San Diego and Orange Counties.

Field Tests: In addition to the consolidation waiver, two separate managed mental health care field tests are currently operating in California counties to test managed care concepts that may be used as the State progresses toward consolidation of mental health services and eventually capitation.

San Mateo

Effective April 1, 1995, all Medi-Cal specialty mental health services, including psychiatric inpatient hospital services, were fully consolidated under the county mental health department. San Mateo County Mental Health directly provides or subcontracts for the provision of services. San Mateo County Mental Health claims the Federal share of Medi-Cal funds through existing Medi-Cal systems. San Mateo receives an allocation from DMH equivalent to the historical State/local match for Medicaid specialty mental health services. Medi-Cal specialty mental health services are reimbursed on a case rate basis, except for pharmacy and laboratory services. Pharmacy and laboratory services are authorized by the field test, but the reimbursement includes a risk corridor delineating State and county risk for the State match when federal dollars are included.

Federal reimbursement is obtained through FFS billing under the SD/MC system. San Mateo County developed its MHP through a participatory local public planning process. The MHP is responsible for all medically necessary specialty mental health services to Medi-Cal beneficiaries. Services are delivered by a combination of county community-based agencies and traditional providers based on a System of Care model.

The primary issues being field tested by San Mateo County are 1) improved access for the consumer through a centrally administered access system; 2) a fully consolidated, publicly managed MHP for all Medi-Cal beneficiaries; 3) the definition of medical necessity; 4) a public/private network service delivery system; 5) innovative contracting arrangements, including shared risk contracting; 6) a program to ensure adequate interface with the primary care system; 7) management infor-

mation needs; and 8) performance outcomes and client satisfaction.

During the waiver period, the provider network was increased to meet service delivery needs. All the specialty mental health providers in good standing who previously had provided services under the County Organized Health System (COHS), a county-based managed health care system, were invited to participate under the county mental health program. The MHP has negotiated contracts with seven hospitals, a number of community-based agencies, and approximately 135 individual mental health providers. Quality of services is being measured by performance and outcome standards related to access, client utilization, and fiscal impact. Client satisfaction is being measured on a regular basis through client satisfaction survey and reviews of client complaints.

Solano

In May 1994, a new COHS was implemented for Medi-Cal services (with the exclusion of SD/MC) for all beneficiaries. Upon implementation, Solano County Mental Health became a subcontractor on a capitated basis to the COHS for all specialty mental health services that were previously provided under fee-for-service/Medi-Cal (FFS/MC). The contract with the COHS places the SD/MC and FFS/MC specialty mental health systems under a single management. The funds, however, are not consolidated and must be accounted for separately, as they are still two separate and distinct funding systems. Solano County Mental Health was required to set up a clear audit trail to ensure that capitated funds from the COHS were not being used to match Federal funds for SD/MC services. Solano County Mental Health retained the responsibility for SD/MC services, which are reimbursed on an FFS basis, and assumes the responsibility for FFS/MC specialty mental health services by establishing separate provider networks and authorization and payment systems in order to maintain a clear audit trail. Administration of the FFS/MC and SD/MC funding streams will be integrated when both are fully capitated. Solano County Mental Health, using capitated dollars from the COHS, has contracted with those private providers who previously provided services under FFS/MC.

The primary issues of the Solano County Mental Health field test include determining management information system needs, medical necessity standards, techniques for managing the scope of benefits, and systems of care design in a managed care environment. Solano County Mental Health has provided training to other county mental health departments and other interested parties regarding their experience with capitation and this field test.

Using a competitive bidding process, Solano County Mental Health developed a contract with a private managed care company to assist with the implementation and management of the capitated services. This public/private partnership has already produced some helpful information for other counties to consider as they make the transition to capitation with respect to strengths and limitations of private behavioral health firms, in areas such as provider relations, information systems, and utilization management.

Solano County Mental Health also contracts with a private, for-profit health maintenance organization (HMO) on a capitated basis to provide mental health services (excluding SD/MC services) for Medi-Cal recipients who select the HMO as their primary health care provider.

Evaluation Findings

- The Latino Coalition for a Healthy California issued a report that finds Medi-Cal's managed care program to be "rife with deficiencies" that, "combined with upheaval fostered by Federal welfare reform, endangers basic health care services to impoverished Latinos and other minorities." Los Angeles is especially precarious; the report finds "inadequate translation of enrollment materials, poor or inaccurate beneficiary education, botched or questionable patient enrollment practices, and paltry payments and support for doctors and hospitals that were the backbone of the old Medi-Cal system."
- A Survey of Consumer Experience with Managed Care conducted in the Sacramento area found that the majority of Sacramento managed care consumers cited no difficulties with their health insurance in the previous year, but that a quarter (27 percent) had problems. Medi-Cal beneficiaries were more likely than others to report problems, with 42 per-

cent of the Medi-Cal beneficiaries surveyed citing difficulty with a managed care plan in the previous 12 months.

- The General Accounting Office released a report in October 1997 that investigated 1) the implementation status of California's managed care expansion, including identifying the primary causes of delays; 2) the degree to which State efforts to educate beneficiaries about their managed care options and enroll them in managed care have encouraged beneficiaries to choose a plan; 3) the management of the State's education and enrollment process for the new program, including State and Federal oversight of enrollment brokers that the state contracted with to carry out these functions; and 4) the impact of the managed care expansion on current safety net providers, such as community health centers. Their investigation found that California's implementation of its 12-county expansion program is more than 2 years behind schedule and is still incomplete. Additionally, the report concluded that the State may have moved too quickly in moving Medicaid recipients into a new system of care. The study showed that recipients were confused by unclear educational material and lack of communication.
- The University of California at Berkeley, commissioned by the Governor's Managed Care Task Force, conducted a study on HMO enrollees' experiences by condition. The study found that in the case of depression, 19 percent of respondents claimed they did not get appropriate care and 26 percent said their health plan didn't cover the benefits they needed.
- Sacramento County Welfare Reform Plan: By January 1997, more than 1,200 health and human services staff members had participated in the training with positive effects shown on the interim evaluation. The net effect for Sacramento County has been an increase in substance abuse treatment slots, significantly reducing waiting lists.

Other Quantitative Data

In 1990, California's health care bill was estimated to be $80 billion; direct cost of treating all mental disorders was estimated to be 10 percent or $8 billion.

COLORADO

OVERVIEW

Colorado currently operates a capitated statewide managed care program for Medicaid mental health services. Medicaid substance abuse services remain in the fee-for-service (FFS) system (only detoxification is provided under a physical health managed care program).

Services under the mental health waiver are provided by nine Mental Health Assessment and Service Agencies (MHASAs) which are organized in one of four different models: community mental health centers (CMHCs) operating independently, a CMHC consortium, partnerships between a behavioral health managed care organization (BHMCO) and community mental health centers, and a nonprofit health maintenance organization (HMO) with an administrative services organization (ASO) arrangement.

Under another waiver program, one county is operating a pilot project that integrates mental health services for the young and elderly disabled populations.

Managed Care Programs for Behavioral Health Services

MEDICAID WAIVERS

Section 1915(b) - Colorado Mental Health Capitation and Managed Care Program (Mental Health): mental health stand-alone: mental-health-specific; substance abuse services reimbursed on an FFS basis.
Section 1115 - Integrated Care and Financing Pilot Project - integrated: mental health services for the elderly and younger disabled.

MEDICAID VOLUNTARY

Not applicable.

OTHER MANAGED CARE PROGRAMS

Not applicable.

Geographic Location

Section 1915(b) - Mental Health: Statewide.

Section 1115 - Integrated Care and Financing Pilot Project: Mesa County (Grand Junction).

Status of Programs

Section 1915(b) - Mental Health: Approved October 1993; implemented August and September 1995; waiver end date June 30, 1997. State submitted a renewal June 1997. This renewal was approved March 1998 and expires March 8, 2000.

Section 1115 - Integrated Care and Financing Pilot Project: Approved August 1997.

Medicaid Substance Abuse Services Remaining Fee-For-Service

Detoxification (inpatient hospitalization).

Medicaid Mental Health Services Remaining Fee-For-Service

Inpatient; outpatient; pharmacy (includes management); mental health support (e.g., case management, personal care); crisis (e.g., emergency services); rehabilitation (e.g., home health).

Medicaid Substance Abuse Services in Managed Care Plan

Section 1915(b) - Mental Health: Covers addiction disorder services only as the services may overlap with mental health services.

Section 1115 - Integrated Care and Financing Pilot Project: Unknown.

Medicaid Mental Health Services in Managed Care Plan

Section 1915(b) - Mental Health: Covered services include inpatient (e.g., hospital services, Institution for Mental Diseases services for individuals under age 21 and over age 65); outpatient; residential (e.g., 24-hour residential care); mental health support (e.g., physician services, case management, respite care, family preservation services, family education and training services, translation/interpretive services for mental health diagnosis and care, vocational and prevocational services); rehabilitation (e.g., psychosocial); crisis (e.g., 24-hour emergency services).

Section 1115 - Integrated Care and Financing Pilot Project: Unknown.

Non-Medicaid Substance Abuse Services in Managed Care Plan

Not applicable.

Non-Medicaid Mental Health Services in Managed Care Plan

Not applicable.

Substance Abuse Prevention and Mental Health Promotion in Managed Care Plan

Section 1915(b) - Mental Health: Prevention services are covered under Colorado's physical health managed care plan. HMOs are required to provide the following services to treat pregnant substance abusing women: health education for mother and child, parenting skills, and life skills education.

Section 1115 - Integrated Care and Financing Pilot Project: Unknown.

Populations Covered Under Managed Behavioral Health

Section 1915(b) - Mental Health: Adults and children mandatory: Aid to Families with Dependent Children/Temporary Assistance for Needy Families, Supplemental Security Income, dually eligible, foster care children.

Section 1115 - Integrated Care and Financing Pilot Project: Voluntary: Elderly, younger disabled, dually eligible (Medicare/Medicaid).

State Managed Care Program Administration

Section 1915(b) - Mental Health: The Medicaid waiver program is administered by the Department of Human Services, Mental Health Services (MHS) under a written memorandum of understanding with the Department of Healthcare Policy and Financing, the State Medicaid agency. The nine MHASAs are organized under four different models:

1. Independent CMHCs. CMHCs operating independently as MHASAs are responsible for both administration and service delivery.
2. CMHC consortium. A separate entity was formed by three CMHCs to operate as a single MHASA. The CMHCs were essentially forced together when the State combined their respective service areas into one managed care region. Behavioral Healthcare Incorporated (BHI) bears full financial risk and acts as a BHMCO. BHI processes claims, authorizes services, and credentials providers. Management information services (MIS) are contracted out to a private data service. BHI pays State hospitals a capitated rate and negotiates FFS payments with both private hospitals and providers.
3. Public/Private partnership between BHMCO and CMHC. Colorado Health Networks consists of three limited liability corporations (LLCs) that provide care in 43 of the State's 63 counties. Each of the three LLCs is composed of a partnership between the CMHC in the region and a private BHMCO. One service center serves all three LLCs. Typically, the CMHC provides mental health services, triages patients, and makes referrals for services not offered by the network. The BHMCO provides MIS, claims processing, utilization review, utilization management, and other administrative services. The LLC partnership's board has equal representation of provider/BHMCO members. The boards are responsible for State guidelines, State contracting, setting general policies, overseeing quality improvement, and approving

budgets for care, administration, and reinvestment of savings. The partnership's contract with the State stipulates that profits must be reinvested.

4. HMO with an ASO arrangement. The State's largest HMO providing physical health services to Medicaid recipients is the newest model to roll out. It is different from the rest of the State in that the State has contracted with a nonprofit HMO, rather than a nonprofit community mental health center as is done in the other parts of the State (see 1 through 3 above). A private for-profit managed care organization will be the ASO in this area of the State (Denver). The HMO will subcontract with several of Denver's behavioral health care providers, including the area's largest behavioral health care provider, MH Corporation (MHC) of Denver. MHC will have a partner role, including a seat at the policy table to influence the contractor's policy decisions. MHC will also receive 46 percent of the Medicaid reimbursement under the contract.

Under these arrangements, the State Mental Health Agency is responsible for policy development, administration, and programmatic oversight for the public and community mental health system. MHASAs are responsible for providing a full range of services and must maintain flexibility to offer new service options not previously available to the Medicaid population. They are responsible for coordinating, managing, and delivering mental health services to all eligible people in their regions. All MHASAs must have a state insurance license, which requires reserves equal to one-twelfth of the projected premiums. CMHCs have their own governing boards. Each CMHC has a geographic service area, but only 1 of 17 is a part of county government.

Section 1115 - Integrated Care and Financing Pilot Project: The Health Care Policy and Financing Department contracts with one private, for-profit HMO to operate the pilot project.

Financing of Plans

Section 1915(b) - Mental Health: This program is financed by Medicaid dollars. The MHASAs are at full risk. Each MHASA is paid a per-person per-month capitated rate, which varies by geographic region and Medicaid eligibility group. Rates are based on historical costs of the FFS system. MHASAs pay network providers FFS. All MHASAs are limited to a before-tax profit of 5 percent of total revenues.

With regard to the public/private LLC partnership between the BHMCO and CMHC, Colorado pays a monthly capitation payment to the LLC. The LLC provides a budget for managed care administration services, which is paid to the BHMCO, and a budget for claims targets, which is paid to the CMHC. The CMHC pays its internal providers, and the BHMCO pays the external providers with this budget. A minimum percentage of what is taken in by the LLC and any surpluses from the two other budgets goes to a risk/reward pool. The partners are at direct risk for a limited amount after depletion of the risk fund, but before the aggregate stop-loss or excess risk coverage becomes active. The risk/reward pool is shared according to a negotiated formula.

Section 1115 - Integrated Care and Financing Pilot Project: Unknown.

Coordination Between Primary and Behavioral Health Care

Section 1915(b) - Mental Health: Medicaid recipients continue to receive their physical and other health services from their Medicaid HMO or primary care physician under the Primary Care Physician Plan (PCPP), while their mental health services are coordinated, provided, or arranged for by their designated MHASA. While there is no formal relationship between the MHASAs and the providers in the PCPP, the MHASAs are required to develop and implement systems for coordinating the mental and physical health care of the Medicaid recipients in their service areas. Some have written agreements with MCOs, but this is largely done on an individual basis.

Additionally, MHASAs have strong incentives to find appropriate placements quickly and must work with the child welfare system to access these placements; child welfare agencies must work with the MHASAs to access needed inpatient hospital services and mental health services for children once they are in residential placements.

Consumer-Family Involvement

Section 1915(b) - Mental Health: Consumer and family involvement at this phase of the waiver has been extremely high with significant, ongoing involvement.

Section 1115 - Integrated Care and Financing Pilot Project: Unknown.

Future Plans

Section 1915(b) - Mental Health: By July 1, 2000, Colorado will have to re-bid the entire State under the Mental Health capitation program.

Section 1115 - Integrated Care and Financing Pilot Project: State plans to expand program statewide.

★ *New Program Under Development:* United Healthcare of Colorado is launching a State health plan for the dually eligible (Medicare/Medicaid) that will operate in the Denver metro area.

State Agency Administration

Colorado's Alcohol and Drug Abuse Division and MHS fall under the auspices of the Department of Human Services. The Medicaid program falls under the Department of Health Care Policy and Financing.

Welfare Reform

Colorado's welfare reform program emphasizes self-sufficiency through employment. An initial assessment of family need for services, skills, prior work experience, and employability is conducted for each individual. The assessment includes identification of domestic violence. Drug testing is not mandatory; however, convicted drug felons do not receive assistance unless they have taken steps toward rehabilitation. Each recipient must complete an Individual Responsibility Plan (IRP). Anyone who refuses to participate in the assessment or does not fulfill the responsibilities of their IRP will not be eligible for cash assistance.

County

Several community mental health centers in Colorado have organized a consortium to participate in the State's mental health capitation program. Three CMHCs formed BHI, a separate entity, to bear risk and act as a behavioral health organization. The partnership formed to avoid overlaps in service areas and cost shifting between service areas. BHI processes claims, authorizes services, and credentials providers. MIS are contracted out to a private data service. BHI pays State hospitals a capitated rate and negotiates FFS payments with private hospitals and providers. CMHCs are at full risk in their State contracts and are required to put up a bond equal to one-twelfth of the projected premiums. In addition, they must qualify as a special type of entity, similar to an HMO as defined under State regulations.

Evaluation Findings

Section 1915(b) - Mental Health: Total estimated savings from the pilot project from August 1995 through June 1996 were $6.5 million. The average cost per unduplicated client without inpatient costs was $2,449, compared with $3,103 before the pilot.

MHS conducts regular site visits to monitor contractor activities and operations. MHS is responsible for ensuring that all necessary mental health services are delivered, that the quality of services delivered meet minimum standards, and that access to services is consistent with level of need. The Institute for Mental Health Services Research has been contracted to conduct an independent evaluation of the pilot program.

MHS contracted for a separate evaluation of children's services under the pilot program as well as a follow-up study of all children and adolescents who were discharged from the two State Mental Health Institutes during the first 2 months of the pilot program. In the follow-up study, researchers focused on whether discharge placements under the capitated system fit the needs of youths. They found that the settings where youth were placed immediately upon discharge did not meet their needs in roughly half the cases. Thus, capitation during the first 2 months of implementation did not substantially alter the number of children who were placed in suitable settings immediately upon discharge. Four months after discharge, however, more parents and clinicians/case managers felt that the placement of youths fit their needs. Other findings included the following:

- Youth who were discharged during early capitation improved in fewer areas of functioning

while hospitalized compared with youth discharged in the previous year; and

- Although parents felt the youth were ready for discharge, clinicians/case managers and parents in both years were dissatisfied with the fit of their child's initial discharge placement in half the cases.

Consumer Satisfaction Survey of Adults Served by the Colorado Mental Health System: Colorado Mental Health Services mailed a consumer satisfaction survey to a random sample of Medicaid recipients identified through mailing lists of CMHCs. The results were fairly positive. Consumers reported the greatest satisfaction with services, locations and hours services were available, staff competence, and respect for consumers' rights. The average overall satisfaction ratings fell between satisfied and neutral. No differences in satisfaction were found based on age or gender. However, with respect to ethnicity, Latino/Hispanic consumers reported higher satisfaction than other groups. Preliminary analysis of satisfaction related to the type of services received found no statistically significant differences in overall satisfaction, although those receiving residential and day treatment services reported the highest levels of satisfaction.

Other Quantitative Data

Not applicable.

CONNECTICUT

OVERVIEW

Connecticut currently operates a managed care program that includes mental health and substance abuse services under a 1915(b) Medicaid waiver. Additionally, the Department of Social Services (DSS) and the Department of Mental Health and Addictions Services (DMHAS) are in the beginning stages of implementing a utilization management program for behavioral health services to the general assistance (GA) (town-administered) and State-administered general assistance (SAGA) populations, under an administrative services organization (ASO) model.

C

Managed Care Programs for Behavioral Health Services

MEDICAID WAIVERS

Section 1915(b) - Connecticut Access - integrated: Acute mental health and substance services are provided as part of physical health services.

MEDICAID VOLUNTARY

Not applicable.

OTHER MANAGED CARE PROGRAMS

GA Behavioral Health Managed Care Program - behavioral health stand-alone: Through an interagency agreement between the DSS and the DMHAS, mental health and substance abuse services will be provided to the GA and SAGA populations under a managed care program.

Geographic Location

Section 1915(b) - Connecticut Access: Statewide.

GA Behavioral Health Managed Care Program: GA: Norwich; SAGA: 11 municipalities.

Status of Programs

Section 1915(b) - Connecticut Access: Submitted February 1995; approved July 1995; implemented February 1, 1997.

GA Behavioral Health Managed Care Program: ASO arrangement will begin October 1, 1998.

Medicaid Substance Abuse Services Remaining Fee-For-Service

Acute detoxification, outpatient detoxification, opiate treatment, outpatient.

Medicaid Mental Health Services Remaining Fee-For-Service

Inpatient, outpatient, Institution for Mental Diseases (IMD) services for individuals age 65 and over and age 21 and under.

Medicaid Substance Abuse Services in Managed Care Plan

Section 1915(b) - Connecticut Access: The following substance abuse services are covered: Acute detoxification, opiate treatment, outpatient.

Medicaid Mental Health Services in Managed Care Plan

Section 1915(b) - Connecticut Access: The following mental health services are covered: Inpatient, outpatient, pharmacy, IMD services for individuals age 65 and over and age 21 and under.

Non-Medicaid Substance Abuse Services in Managed Care Plan

GA Behavioral Health Managed Care Program: Acute detoxification, opiate treatment, outpatient, residential.

Non-Medicaid Mental Health Services in Managed Care Plan

GA Behavioral Health Managed Care Program: Inpatient, outpatient, crisis, and partial hospitalization.

Substance Abuse Prevention and Mental Health Promotion in Managed Care Plan

Section 1915(b) - Connecticut Access: Early and periodic screening, diagnosis, and treatment; dental, vision, hearing, and other preventive services.

GA Behavioral Health Managed Care Program: None.

Populations Covered Under Managed Behavioral Health

Section 1915(b) - Connecticut Access: Mandatory adults and children: Aid to Families with Dependent Children/Temporary Assistance for Needy Families (AFDC/TANF), pregnant women and children up to 200 percent Federal poverty level (FPL), uninsured children (including foster care children) up to 185 percent FPL; uninsured children above 185 percent FPL covered under the State's Children's Health Insurance Program (CHIP).

GA Behavioral Health Managed Care Program: GA and SAGA populations. Income eligibility is determined by comparing the individual's available income to the payment standard; FPL does not apply.

State Managed Care Program Administration

Section 1915(b) - Connecticut Access: Currently, the DSS contracts with seven private, for-profit health maintenance organizations (HMOs) and two federally qualified health centers on a fully capitated basis. Five plans subcontract with a behavioral health managed care organization for behavioral health services, and two provide services directly. Medicaid is responsible for monitoring, and the HMOs are responsible for coordinating and providing direct services.

The provider network is closed; plans are required to use school-based health centers and child guidance clinics as part of the traditional community provider network.

Plans are mandated to contract with Medicaid-reimbursed school-based clinics to refer emotionally disturbed children to guidance centers or alternative providers if plans don't provide these services themselves. The plans are responsible to DSS for their providers and subcontractors.

GA Behavioral Health Managed Care Program: Currently, an interagency agreement between DSS and DMHAS has been established to govern the transition and ongoing coordination of behavioral health services to recipients of SAGA and GA programs. DMHAS contracted with an ASO to provide claims process and utilization management for substance abuse treatment as well as mental health services for the GA population.

Currently, DMHAS uses Medicaid, DMHAS-contracted providers, and State-operated facilities to deliver behavioral health services. During the fall of 1998, providers will be credentialed. Providers will not contract with the ASO but with DMHAS.

DSS played a strong role, in concert with its provider system, in guiding this program. It is working toward establishing criteria for diagnoses, length of stay, and level of care determinations, and setting new rate structures.

DSS is responsible for providing space and equipment, supplying security and parking, and working collaboratively with DMHAS workers for the mutual benefit of SAGA and GA recipients. DMHAS' responsibilities include providing services to SAGA/GA clients either directly or through referrals, staffing, supervising, authorizing services, processing claims, and working collaboratively with DSS.

Financing of Plans

Section 1915(b) - Connecticut Access: This program is financed through Medicaid dollars. HMOs are paid a capitated rate based on 92.5 percent of historical fee-for-service (FFS) per capita expenditures. Plans are required to purchase private insurance in order to pass through the Request for Applications process. The State assumed a 5 percent managed care savings. Plans are fully capitated, with school-

based child health services for children with special health care needs and Part H early intervention services excluded from the capitated rates and paid on an FFS basis. If a plan generates a profit, there are no mandates on how these profits are allocated.

GA Behavioral Health Managed Care Program: DMHAS received an appropriation for managed behavioral health care for the State's GA recipients. The ASO and provider network will not be put at risk. Services will be reimbursed on an FFS basis. Providers will be paid from a Connecticut Treasury-approved ASO bank account.

Coordination Between Primary and Behavioral Health Care

Section 1915(b) - Connecticut Access: Coordination is up to the individual health plans. Standard managed care utilization review is used.

GA Behavioral Health Managed Care Program: Not applicable.

Consumer-Family Involvement

Section 1915(b) - Connecticut Access: Consumers and families are members of an advisory council that is currently active, even upon implementation of the waiver. In addition, the State legislature gave money to the Child Health Council to monitor the impact of the program on children. Also, an enrollment broker arranged for a family advisory group to empower families of consumers accessing behavioral health services.

GA Behavioral Health Managed Care Program: Consumers and family members played a role in the design of the program. Additionally, DMHAS has a very active consumer council to advise on the implementation and operation of the program.

Future Plans

Section 1915(b) - Connecticut Access: The dually eligible (Medicaid/Medicare) are expected to be phased in within 2 years.

GA Behavioral Health Managed Care Program: The ASO arrangement will begin October 1, 1998.

★ *New Program Under Development:* The HUSKY plan (CHIP) will serve children from 185 to 300 percent FPL. Inpatient and outpatient mental health and substance abuse services will be provided. Two additional initiatives within the HUSKY plan administered by the Yale Child Study Center include children in need of intensive behavioral health services and children with special physical health needs. These two programs fall under the auspices of HUSKY Plus. The infrastructure of Child Guidance Clinics, Family Service Agencies, and Youth Service Bureaus will be used.

Providers will be paid from a combination of supplemental grants and direct service dollars to provide care coordination, case management, and direct services. Programs will be administered by Title V administration. The program is expected to be implemented July 1, 1998.

State Agency Administration

DSS houses the Medicaid agency, and DMHAS houses the Mental Health and Substance Abuse agencies.

Welfare Reform

Under Connecticut's welfare reform plan, women who receive AFDC or GA funds and enter substance treatment without their children must forfeit all welfare benefits. Women who enter substance abuse treatment with their children must pay part of the cost of their treatment (generally, one-third of the total cost). Women who have children and are enrolled in a job-training program receive a cash stipend to be used toward child care expenses. Women with children who are receiving substance abuse treatment services are given no child care stipend. Additionally, Connecticut does not mandate drug testing for all welfare beneficiaries. TANF is not denied to drug felons.

Recently, Connecticut cut off welfare to hundreds of families who reached the State's 21-month time limit. This process is expected to eliminate one-fifth of the State's welfare caseloads by November 1998.

County

Not applicable.

Evaluation Findings

Section 1915(b) - Connecticut Access: For the first waiver, DSS (in conjunction with EQRO (external quality review organization) and the Child Health Council) collected encounter data to monitor the quality of care provided by both types of health plan, basing the indicators monitored on HEDIS (Health Employer Data and Information Set). Monthly reports are provided to the advisory council (see Consumer-Family Involvement Section).

Other Quantitative Data

Not applicable.

DELAWARE

OVERVIEW

Delaware's Diamond State Health Plan provides a basic benefit plan that includes medical and limited mental health/substance abuse benefits through a managed care delivery system. Specialty mental health and substance abuse services for children with severe emotional disturbance (SED) are partially carved out and managed by a public sector managed care organization (MCO) (the Department of Services for Children, Youth, and their Families (DSCYF), Division of Child Mental Health Services (DCMHS)).

For adults, limited mental health and substance abuse treatment services are included in the Diamond State Health Plan. Mental health and substance abuse services for adults with severe and persistent illness are provided through the Department of Health and Social Services (DHSS) Division of Alcoholism, Drug Abuse, and Mental Health (DADAMH), through State-operated and contractual programs.

Additionally, DSCYF operates a child welfare demonstration to provide behavioral health services to families whose children might otherwise be placed in out-of-home care.

Managed Care Programs for Behavioral Health Services

MEDICAID WAIVERS

Section 1115 - Diamond State Health Plan - partial carve-out: Integrates basic mental health and substance abuse services; specialty mental health and substance abuse services are carved out for children and fee-for-service (FFS) for adults.

MEDICAID VOLUNTARY

Not applicable.

OTHER MANAGED CARE PROGRAMS

Child Welfare Demonstration - integrated: Provides assisted guardianship placements for children who cannot be reunited with their parents, as well as substance abuse treatment for parents to reduce the need for foster care placements.

Geographic Location

Section 1115 - Diamond State Health Plan: Statewide.

Child Welfare Demonstration: Statewide.

Status of Programs

Section 1115 - Diamond State Health Plan: Submitted July 27, 1994; approved May 16, 1995; implemented January 1, 1996.

Child Welfare Demonstration: Approved June 17, 1996.

Medicaid Substance Abuse Services Remaining Fee-For-Service

The Delaware Medicaid program covers the following substance abuse services: Acute, subacute, and ambulatory detoxification; opiate treatment; outpatient; inpatient; transportation.

Medicaid Mental Health Services Remaining Fee-For-Service

The Delaware Medicaid program covers the following mental health services: inpatient, outpatient, pharmacy, mental health support, Institution for Mental Diseases waiver services for those under age 21.

Medicaid Substance Abuse Services in Managed Care Plan

Section 1115 - Diamond State Health Plan: Basic Plan: For children: outpatient up to 30 units. For adults: inpatient services up to 30 units and outpatient services up to 20 units.

Specialty Plan: For children: Inpatient; acute, subacute, and/or ambulatory detoxification; opiate treatment; residential. For adults: Specialty substance abuse services not included in the managed care program.

Medicaid Mental Health Services in Managed Care Plan

Section 1115 - Diamond State Health Plan: Basic Plan: For children: Outpatient up to 30 units; emergency transportation. For adults: Inpatient services up to 30 units and outpatient services up to 20 units; emergency transportation.

Specialty Plan: For children: Inpatient, crisis, mental health support, mental health rehabilitation, residential. For adults: After 30 visits if an individual is not determined to have severe and persistent illness (SPI), the individual is served in one of the Division's programs with non-Medicaid funding. For those with SPI, the individual is served in one of the Division's programs with Medicaid funding.

Non-Medicaid Substance Abuse Services in Managed Care Plan

Child Welfare Demonstration: Unknown.

Non-Medicaid Mental Health Services in Managed Care Plan

Child Welfare Demonstration: Unknown.

Substance Abuse Prevention and Mental Health Promotion in Managed Care Plan

Section 1115 - Diamond State Health Plan: Early and periodic screening, diagnosis, and treatment (EPSDT); routine physicals; immunizations.

Child Welfare Demonstration: EPSDT.

Populations Covered Under Managed Behavioral Health

Section 1115 - Diamond State Health Plan: Mandatory adults and children: Aid to Families with Dependent Children/Temporary Assistance for Needy Families (AFDC/TANF), uninsured (up to 100 percent Federal poverty level (FPL)), Supplemental Security Income, adults (up to 100 percent FPL); pregnant women (up to 185 percent FPL); children age 0–1 (up to 185 percent FPL); children age 2–5 (up to 133 percent FPL); children age 5–18 (up to 100 percent FPL).

Child Welfare Demonstration: Foster children; children at risk for out-of-home placement and their parents.

State Managed Care Program Administration

Section 1115 - Diamond State Health Plan: The Diamond State Health Plan is a public/private partnership composed of three commercial MCOs and one public sector MCO. Medicaid contracts with the commercial MCOs to provide services in the basic benefit package. Commercial MCO responsibilities include delivery of acute physical and behavioral health services. Two of the three commercial MCOs subcontract with behavioral health service companies to provide the services. The third commercial MCO contracts on an FFS basis with community providers. The MCOs may contract exclusively as long as all necessary services are provided by the contracting network.

The role assigned by the 1115 Medicaid Waiver for DSCYF is that of a public MCO, to partner with the private MCOs. Affiliation agreements between DSCYF and each of the MCOs have been established. After the adult or child exhausts the inpatient and outpatient units, DCMHS and DADAMH oversee the provision of services beyond those offered by the MCOs in the basic benefit package.

Child Welfare Demonstration: DSCYF administers the child welfare demonstration. Delaware staffs joint child protective services and substance abuse teams to provide services to families whose children might otherwise have to be placed or remain in foster care.

Financing of Plans

Section 1115 - Diamond State Health Plan: Basic Plan: The MCOs are fully capitated, at risk, and paid by the Medicaid Office DHSS, Division of Social Services. All services in the managed care benefit package are paid by monthly capitation payments based on the State's previous FFS Medicaid experience trended to rate year and adjusted for expected effects of managed care on utilization and expenditures. MCOs must self-insure or purchase private insurance; the State does not engage in risk sharing through stop-loss or risk corridors.

The providers in the Diamond State Health Plan are at full risk for the populations served. The MCOs may negotiate the type of contract with their providers. Capitation rates for the Diamond State Health Plan were calculated with anticipated savings. There are no restrictions on how any other savings must be used by the MCOs or mandates on profit allocation.

Partial carve-out for SED children: A "bundled rate" has been established as the new method of payment by the Medicaid Office for the services delivered to Medicaid-eligible children by DCMHS. This is paid on a per-member per-month basis for each Medicaid child receiving a service during that month. In the future, DSCYF will establish a set capitation rate for every Medicaid-eligible child.

Child Welfare Demonstration: This program is funded through Federal foster care Title IV-E funds.

Coordination Between Primary and Behavioral Health Care

Section 1115 - Diamond State Health Plan: For adults, primary or specialty physical health care services are coordinated according to each MCO's policy and procedures. Care for children is coordinated on a case-by-case basis.

Child Welfare Demonstration: Unknown.

Consumer-Family Involvement

Section 1115 - Diamond State Health Plan: The Medicaid Managed Care steering committee had large representation of mental health and substance abuse consumers. Its focus was on the implementation of the Diamond State Health Plan. Upon implementation, however, the committee's work was completed, and consequently, the committee no longer meets.

Child Welfare Demonstration: Unknown.

Future Plans

Section 1115 - Diamond State Health Plan: The Diamond State Health Plan will incorporate the Title XXI Children's Health Insurance Program (CHIP) (see below for description).

★ *New Program Under Development:* DHSS is currently undertaking a feasibility study on long-term managed care. Populations/groups included in the feasibility study are all individuals receiving long-term care services by the Department, such as the elderly and persons with physical disability, mental retardation, severe and persistent mental illness, and alcoholism or drug addictions.

Based on the results of the feasibility study, the State decided to develop a Managed Long-term Care Program for its 1915 populations and the dual eligibles. Program components are being developed for older adults and adults with behavioral health problems. It is anticipated that a full request for proposals (RFP) and waiver initiative will begin in late 1998 or early 1999.

★ *New Program Under Development:* Delaware released an RFP due April 13, 1998, for Adults with Severe Developmental and Behavioral Disabilities in the Adult Special Populations Program.

★ *New Program Under Development:* An insured program for children using Federal CHIP funding will provide services to children up to age 19 not qualified for Medicaid but below 200 percent FPL. These children will be able to enroll in a managed care plan. The State will use $8.1 million in Federal funds and $3.5 million in State funds to finance the program. The proposal for this program was due July 1, 1998. The program is expected to begin January 1999, depending on Federal approval process.

State Agency Administration

The DHSS houses the Medicaid agency as well as the Mental Health and Substance Abuse agencies for adults. The Division of Social Services (DSS), Office of Medicaid represents the Medicaid agency. DADAMH serves adults. The DSCYF and DCMHS serve children and adolescent mental health and substance abuse needs.

Welfare Reform

Delaware negotiated an interagency partnership with the substance abuse agency (DADAMH) to provide substance abuse intensive case management and intervention services for TANF recipients. TANF funds will be used to support the "Bridge Agency" project.

Currently, under the Personal Responsibility and Work Opportunities Reconciliation Act, drug testing is not mandatory and those TANF eligible individuals who commit a drug felony will be denied coverage.

- Delaware's statewide reform project, A Better Chance Welfare Reform Program, includes a 2-year time limit on cash assistance, required school attendance for dependent children and minor parents, a family cap, a required contract of mutual responsibility and related work requirements, and required immunizations. Recipients have access to information on family planning services, domestic violence intervention, and substance abuse treatment.

A Better Chance also includes an initiative for parenting, employment, and training for absent fathers; individual savings accounts and the ability for clients to retain a portion of their grants while working; elimination of the 100-hour rule and other barriers for two-parent families; and ongoing child care and health care coverage, including counseling, for clients who leave welfare to work.

Also, under this program, two DHSS Divisions—DADAMH and DSS—are linked together to develop a process of identifying and serving welfare recipients in need of mental health and substance abuse services. These individuals will have access to the basic behavioral health care benefit package under the Diamond State Health Plan. Individuals can be sanctioned for not complying with substance-abuse-related requirements.

- Delaware's Welfare to Work grant submitted to the U.S. Department of Labor on February 19, 1998, is pending approval. This grant will be administered by DSS, within DHSS. One hundred percent of matching funds will come from the State. The intended use of 15 percent State project funds will be based upon innovative proposals by public/nonprofit and private organizations that show promise in moving the most-difficult-to-employ long-term welfare recipients into unsubsidized employment. The State's welfare reform program, A Better Chance, will coordinate efforts to link Welfare to Work entities with local TANF agencies. Performance measures from A Better Chance will be used.

County

Not applicable.

Evaluation Findings

Section 1115 - Diamond State Health Plan: Plans must track and seek to improve health outcomes based on EPSDT guidelines developed by U.S. Preventive Services Task Force. Plans are required to conduct annual satisfaction surveys. Plans must submit semi-annual reports on quality assurance activities and results (including HEDIS (Health Employer Data and Information Set) and other clinical outcomes measures).

Specifically, the State and State's contracting MCOs conducted a consumer satisfaction survey in 1997 using 1996 data.

Other Quantitative Data

Not applicable.

DISTRICT OF COLUMBIA

OVERVIEW

Acute mental health and substance abuse services are excluded from the District's mandatory health maintenance organization (HMO) program and provided on a fee-for-service (FFS) basis.

For specialty mental health and substance abuse services, the District is operating a managed care waiver that fully integrates physical health, mental health, and substance abuse services for persons age 21 and under who receive Supplemental Security Income (SSI) benefits.

Managed Care Programs for Behavioral Health Services

MEDICAID WAIVERS

Section 1115 - Health Services for Children with Special Needs (HSCSN) - general health - integrated: Physical, mental health, and substance abuse services are provided for children and adolescents with disabilities and chronic illnesses.

MEDICAID VOLUNTARY

Not applicable.

OTHER MANAGED CARE PROGRAMS

Not applicable.

Geographic Location

Section 1115 - HSCSN: District-wide.

Status of Programs

Section 1115 - HSCSN: Submitted March 1994; approved October 13, 1995; implemented December 15, 1995.

Medicaid Substance Abuse Services Remaining Fee-For-Service

The District does not have a defined set of substance abuse services; however, all medically necessary services are covered when accessed through a clinic, hospital, or physician.

Medicaid Mental Health Services Remaining Fee-For-Service

The District does not have a defined set of mental health services; however, all medically necessary services are covered when accessed through a clinic, hospital, or physician.

Medicaid Substance Abuse Services in Managed Care Plan

Section 1115 - HSCSN: The plan for children with special needs provides the following substance abuse services: inpatient service (inpatient substance abuse services to stabilize acute substance abuse conditions); outpatient services.

Medicaid Mental Health Services in Managed Care Plan

Section 1115 - HSCSN: The plan for children with special needs provides the following mental health services: inpatient; outpatient (e.g., clinic services, hospital outpatient department); mental health rehabilitation; prescription drugs; Institution for Mental Diseases services for individuals under age 22.

Non-Medicaid Substance Abuse Services in Managed Care Plan

Not applicable.

Non-Medicaid Mental Health Services in Managed Care Plan

Not applicable.

Substance Abuse Prevention and Mental Health Promotion in Managed Care Plan

Section 1115 - HSCSN: Early and periodic screening, diagnosis and treatment (EPSDT) services for children under age 21; preventive diagnostic and screening services.

Populations Covered Under Managed Behavioral Health

Section 1115 - HSCSN: Children voluntary: SSI.

State Managed Care Program Administration

Section 1115 - HSCSN: The District's Medicaid agency contracts with HSCSN, a private, not-for-profit managed care entity that is responsible for developing a provider network that provides the complete range of Medicaid services. HSCSN contracts with any willing provider.

Financing of Plans

Section 1115 - HSCSN: The program is financed by Medicaid dollars. The District's Medicaid agency makes capitation payments to HSCSN, which is at partial risk. The Medicaid agency requires HSCSN to spend 85 percent of funds on claims or it will take back the difference. The capitation rate is based on historical usage. Providers are paid on an FFS basis.

Coordination Between Primary and Behavioral Health Care

Section 1115 - HSCSN: HSCSN provides both physical and mental health services.

Consumer-Family Involvement

Section 1115 - HSCSN: None.

Future Plans

Section 1115 - HSCSN: This program ends in December 1998. There are no plans yet as to next steps.

State Agency Administration

The Medicaid authority, the Medical Assistance Administration, and the substance abuse authority, the Addictions Prevention and Recovery Administration, are under the Department of Health. The mental health authority is the Commission on Mental Health Services, under the auspices of the Mental Health Receiver.

Welfare Reform

The District's Temporary Assistance for Needy Families (TANF) plan became effective December 3, 1996. The plan stipulates denying TANF benefits to drug felons. The District does not require drug testing of recipients.

County

Not applicable.

Evaluation Findings

Evaluations are in process.

Other Quantitative Data

Not applicable.

FLORIDA

OVERVIEW

Medicaid managed care is delivered through three vehicles in Florida: A statewide primary care case management plan, a statewide voluntary health maintenance organization (HMO) program, and a mental health stand-alone in the Tampa Bay area. Statewide, all recipients may choose between the HMO program and the primary care case management (PCCM) plan for physical health services. Except in the Tampa Bay area, community mental health and substance abuse services are excluded from these plans and provided on a fee-for-service FFS basis. In Tampa Bay, however, recipients who choose the PCCM plan are referred to a mental health stand-alone program, known as the Florida Prepaid Mental Health Plan (PMHP). Recipients who choose the HMO receive all of their services, including mental health and substance abuse treatment, from the HMO. However, HMOs in the Tampa Bay area subcontract with the carve-out subcontracted providers.

Three other managed care programs are operating in the State: A child welfare initiative that includes behavioral health services; a capitation program for all social services including substance abuse; and a Medicaid utilization management program for all inpatient psychiatric visits.

Managed Care Programs for Behavioral Health Services

MEDICAID WAIVERS

Section 1915(b) - Florida PMHP - mental health stand-alone: Provides mental health services only to Medipass enrollees in the five-county Tampa Bay area on a mandatory basis.

MEDICAID VOLUNTARY

Not applicable.

OTHER MANAGED CARE PROGRAMS

Department of Children and Families - child welfare program - integrated: District offices of the Department of Children and Families, which administer State general fund programs for behavioral health, have contracted with Medicaid to coordinate diversion and aftercare efforts by community-based behavioral health care providers. Medicaid recipients who present at inpatient hospitals for psychiatric care will be served. Additionally, the district offices will oversee case planning for "high use" Medicaid recipients.

Capitation plan - substance abuse stand-alone: Starting in July 1995, Florida began to capitate its funding to social service district offices for all social services, including substance abuse.

Behavioral Health Care Utilization Management Service - Medicaid program - behavioral health stand-alone: reviews inpatient psychiatric services for Medicaid recipients who remain in the FFS system.

Geographic Location

Section 1915(b) - PMHP: Five counties (Hardee, Highland, Hillsborough, Manatee, and Polk).

Department of Children and Families: Unknown.

Capitation plan: Statewide.

Behavioral Health Care Utilization Management Service: Statewide.

Status of Programs

Section 1915(b) - PMHP: Original submission date: unknown. Original approval date: unknown. Implemented March 1, 1996. Renewal application submitted January 14, 1998. Extension granted until August 27, 1998.

Department of Children and Families: Unknown.

Capitation plan: Implemented July 1995.

Behavioral Health Care Utilization Management Service: Implemented January 1997.

Medicaid Substance Abuse Services Remaining Fee-For-Service

Ambulatory detoxification, outpatient, opiate treatment programs, inpatient.

Medicaid Mental Health Services Remaining Fee-For-Service

Inpatient; outpatient; mental health rehabilitation (e.g., community-based facility care, targeted case management); Institution for Mental Diseases (IMD) services for individuals age 65 and over.

Medicaid Substance Abuse Services in Managed Care Plan

Section 1915(b) - PMHP: Not applicable.

Behavioral Health Care Utilization Management Service: Not applicable.

Medicaid Mental Health Services in Managed Care Plan

Section 1915(b) - PMHP: Inpatient; outpatient; mental health rehabilitation (e.g., targeted case management); mental health support (e.g., community mental health). Statewide, HMOs cover inpatient and outpatient hospital mental health services and psychiatrist services. In the Tampa Bay area, HMOs also cover community mental health and mental health targeted case management. The PMHP is allowed to use IMDs as a downward substitution for inpatient treatment when it is determined to be appropriate and medically necessary for recipients of all ages.

Behavioral Health Care Utilization Management Service: Inpatient.

Non-Medicaid Substance Abuse Services in Managed Care Plan

Department of Children and Families: Unknown.

Capitation plan: Unknown.

Non-Medicaid Mental Health Services in Managed Care Plan

Department of Children and Families: Unknown.

Capitation plan: Not applicable.

Substance Abuse Prevention and Mental Health Promotion in Managed Care Plan

Section 1915(b) - PMHP: Early and periodic screening, diagnosis, and treatment (EPSDT). HMOs are also required to provide six quality and benefit enhancements regarding substance abuse and child wellness.

Department of Children and Families: Unknown.

Capitation plan: Unknown.

Behavioral Health Care Utilization Management Service: Not applicable.

Populations Covered Under Managed Behavioral Health

Section 1915(b) - PMHP: Children and adults mandatory: Aid to Families with Dependent Children (AFDC), Supplemental Security Income (SSI), Seventh Omnibus Budget Reconciliation Act (SOBRA).

Department of Children and Families: Children voluntary: AFDC, SSI, and SOBRA.

Capitation plan: Unknown.

Behavioral Health Care Utilization Management Service: Not applicable.

State Managed Care Program Administration

Section 1915(b) - PMHP: The Agency for Health Care Administration (Medicaid) contracts with Florida Health Partnership (FHP). FHP is a partnership between five community mental health centers that incorporated as a nonprofit organization named Florida Behavioral Health, Inc., and a private managed care organization. The managed care organization serves as the managing partner responsible for administration, utilization management, quality improvement, medical economics, network management, and management information systems. Florida Behavioral Health, Inc., is responsible for the delivery of mental health services. FHP has not replaced any function traditionally performed by Medicaid or the Department of Children and Families.

Department of Children and Families: The Department of Children and Families has lead responsibility for this program.

Capitation plan: Unknown.

Behavioral Health Care Utilization Management Service: Medicaid contracts with a private utilization review firm to provide some administrative functions.

Financing of Plans

Section 1915 - PMHP: The source of funds is Medicaid dollars. FHP assumes full risk for this program. Medicaid resources previously spent on mental health services in the demonstration area were capped and contracted to FHP to manage. The State developed capitation rates using a federally approved methodology. The request for proposals (RFP) included rates that were at the upper payment limit of Medicaid's projected FFS expenditures for similar services to any actuarially equivalent population of recipients. The RFP required responding providers to specify in their rate proposals the percentage of the upper payment level rates that would be acceptable. Rate proposals were required to reflect bids between 92 and 100 percent of the upper payment level. The State stipulated that the capitation rate methodology would be as described in the RFP, but the actual capitation rates of payment would be developed for the applicable contract period. The winning proposal bid 92 percent. In the first 3 years of the waiver, a capitation rate of 92 percent has been paid.

Department of Children and Families: The source of funding for this program is State general funds.

Capitation plan: Funds for this program come from the Medicaid agency and State funds. The local districts are responsible for allocating these resources in a fashion consistent with their local objectives, as well as cutting services to meet the budget targets established by the State. Districts may shift funds from one district to another.

Behavioral Health Care Utilization Management Service: The program is funded by Medicaid funds. The utilization review firm is paid a flat fee for services.

Coordination Between Primary and Behavioral Health Care

Section 1915(b) - Florida PMHP: In the Tampa Bay area, the Medicaid agency provides information to Medipass primary care physicians regarding their enrollees' PMHP. This facilitates primary care physician referrals to appropriate mental health providers. The Medicaid agency is providing training to area Medicaid providers about the PMHP, thus alerting physicians, hospitals, and other providers about referral to PMHP.

Department of Children and Families: Unknown.

Capitation plan: Not applicable.

Behavioral Health Care Utilization Management Service: Not applicable.

Consumer-Family Involvement

Florida is among the first states to implement an ombudsman program for managed care consumers. The ombudsman, who works for all managed care organizations including Medicaid, will be responsible for resolving disputes between health plans and consumers. The program was initiated by State legislation and puts the power of a state regulatory agency behind the program, which is expected to make it even more effective.

Section 1915(b) - PMHP: The PMHP and the HMOs in the pilot area are members of a Managed Behavioral Healthcare Advisory Group, that convenes quarterly to report on advocacy and programmatic concerns. The membership is composed of representatives from the Agency for Healthcare Administration, program supervisors from the local Alcohol, Drug Abuse, and Mental Health Program Offices, the local mental health and substance abuse providers, local consumer advocacy groups, and consumers and family members of consumers. The Advisory Group is responsible for providing technical and policy advice to the Agency concerning the provision of services to its members. The Managed Behavioral Healthcare Advisory Group has consumer and family representation from all five counties involved in this project. In addition, the agency conducts a Statewide Managed Care Advocacy Workgroup and holds monthly meetings responding to managed care issues and reporting on upcoming initiatives. The local advisory group's function is to provide technical and policy advice to the agency regarding the plan's provision of services. The quarterly meetings are attended by the advisory group members, the PMHP and HMO contract managers from Tallahassee and Tampa, representatives from all of the HMOs providing services in the area, representatives from the PMHP, community mental health providers, district program administrators from the Department of Children and Families, and an administrator from the State hospital serving that area of the State. When concerns are raised by this advisory group, the other individuals in attendance have the authority to address their concerns and implement recommended changes.

Department of Children and Families: Unknown.

Capitation plan: Unknown.

Behavioral Health Care Utilization Management Service: Not applicable.

Future Plans

Section 1915(b) - PMHP: At end of the 2-year pilot, the contract will be evaluated and substance abuse services may be added at that time. In addition, planning is under way to evaluate the PMHP program in one area.

Department of Children and Families: Unknown.

Capitation plan: Unknown.

Behavioral Health Care Utilization Management Service: The utilization management service contract is a 30-month contract with the option for two 1-year extensions at the end of the 30 months.

State Agency Administration

The Division of Medicaid and the Division of Health Quality Assurance are housed in the Agency for Health Care Administration. The mental health authority, the Mental Health Program Office, and the substance abuse authority, the Office for Substance Abuse Treatment, are housed within the Department of Children and Families.

Welfare Reform

Florida has adopted its Work and Gain Economic Self Sufficiency (WAGES) as its Temporary Assistance for Needy Families plan. The plan became effective October 1, 1996. The program does not deny benefits to drug felons whose crimes do not include drug trafficking. It does not test recipients for drug use. Additionally, the program provides for personal or family counseling or therapy, including substance abuse, if necessary for a WAGES participant to secure or retain a job.

County

Duval County: A project in Duval County covers behavioral health for child welfare children. Funding for the program is provided by Child Welfare, Medicaid, mental health, juvenile justice, and substance abuse. Both a Medicaid waiver and Title IV-E waiver are pending. The State Alcohol, Drug Abuse and Mental Health Office manages preauthorization for care, tracks data, and creates provider networks. There are no plans to share financial risk with providers.

Evaluation Findings

The Agency for Health Care Administration has contracted with the Florida Mental Health Institute (FMHI) at the University of South Florida to evaluate the State's current mental health system. The contract is in effect from July 15, 1996, through March 1, 1999. FMHI will be comparing cost, utilization, quality, and access for three systems of care: FFS, managed care (carve-in/HMOs), and the PMHP carve-out. The final product, due March 1, 1999, will be an evaluation of the systems with recommendations based on issues identified in the study.

Other Quantitative Data

Section 1915(b) - PMHP: During calendar year 1997, the average enrollment for the PMHP was approximately 58,754 members. The service penetration rate for 1997 was 11.2 percent, or 6,583 unduplicated members. The average length of stay for inpatient treatment was 6.6 days.

In the first 3 years of the waiver a capitation rate of 92 percent has been paid, which should provide a savings of 8 percent of FFS expenditures annually. The State is currently working on cost-effectiveness data for waiver renewal and does not yet have actual cost savings data available to report.

GEORGIA

OVERVIEW

Georgia Medicaid is not actively pursuing managed behavioral health care; behavioral health services are currently in the fee-for-service system. In September 1995, Georgia submitted a Section 1115 waiver to the Health Care Financing Administration, known as the Georgia Behavioral Health Plan. The State withdrew its application.

On the local level, however, a public nonprofit community mental health, mental retardation, and substance abuse provider, community service board (CSB), in south Georgia has contracted with a managed behavioral health company for administrative services only (ASO). Services covered within this effort include 24-hour telephone triage, prospective service authorization, and network management services. Ten counties are covered for services under this contract.

Managed Care Programs for Behavioral Health Services

MEDICAID WAIVERS

Not applicable.

MEDICAID VOLUNTARY

Not applicable.

OTHER MANAGED CARE PROGRAMS

CSB/ASO program - behavioral health stand-alone: Local mental health and substance abuse program with ASO arrangement.

Geographic Location

CSB/ASO program: 10 counties: Lowndes, Turner, Ben Hill, Irwin, Tift, Berrien, Cook, Brooks, Lanier, and Echols. These are the only counties included in the CSB/ASO contract.

Status of Programs

CSB/ASO program: Implemented November 1997.

Medicaid Substance Abuse Services Remaining Fee-For-Service

Detoxification; opiate treatment (e.g., methadone maintenance); outpatient (e.g., diagnostic assessment, nursing assessment, health referrals, counseling); crisis (e.g., emergency services, crisis intervention or crisis stabilization); inpatient (e.g., acute care).

Medicaid Mental Health Services Remaining Fee-For-Service

Inpatient (e.g., acute care); outpatient (e.g., clinic services); mental health rehabilitation (e.g., targeted mental health, mental retardation, and substance abuse case management); prescription drugs; psychological services (for children only); therapeutic residential intervention services (for children only); physician/psychiatrist services.

Medicaid Substance Abuse Services in Managed Care Plan

Not applicable.

Medicaid Mental Health Services in Managed Care Plan

Not applicable.

Non-Medicaid Substance Abuse Services in Managed Care Plan

CSB/ASO program: Not applicable.

Non-Medicaid Mental Health Services in Managed Care Plan

CSB/ASO program: Not applicable.

Substance Abuse Prevention and Mental Health Promotion in Managed Care Plan

CSB/ASO program: Not applicable.

Populations Covered Under Managed Behavioral Health

CSB/ASO program: Individuals served under this contract are those with mental illness, mental retardation, or substance abuse who are supported by State allocations.

State Managed Care Program Administration

CSB/ASO program: One community service board contracts with a managed behavioral health company to provide 24-hour telephone triage, prospective service authorization, and network management services.

Financing of Plans

CSB/ASO program: State mental health, mental retardation, and substance abuse allocations pay for the ASO contract.

Coordination Between Primary and Behavioral Health Care

CSB/ASO program: Not applicable.

Consumer-Family Involvement

CSB/ASO program: Not applicable.

Future Plans

★ *New Program Under Development:* The Departments of Medical Assistance, Human Resources, Education, and Juvenile Justice are participating in a study of children's behavioral health needs. As part of this study, they are examining successful managed behavioral health services for children in other States.

State Agency Administration

Mental health and substance abuse are housed together in the Division of Mental Health, Mental Retardation and Substance Abuse (DMHMRSA), under the Department of Human Services. The Georgia Department of Medical Assistance is responsible for Medicaid programs.

Welfare Reform

Georgia's Temporary Assistance for Needy Families (TANF) plan, which became effective in January 1997, stipulates denying TANF benefits to drug felons. The plan does not test its recipients for drug use.

Georgia submitted a Welfare-to-Work plan in December 1997. The administrative agencies for the plan are Department of Labor, Department of Human Resources, and Department of Technical and Adult Education. Substance abuse treatment is funded under this plan and provided through the State DMHMRSA and its contractors.

MHMRSA is participating in joint initiatives with the Division of Family and Children Services (DFCS) to address needs of pregnant or parenting women and their children. The efforts include planning to use funds available under the welfare reform initiative for treatment services to DFCS recipients. Both agencies are increasing collaboration at the local level to engage families in treatment and prevent removal of children from parental custody because of substance abuse problems. Currently, training is under way for MHMRSA providers statewide on substance abuse services to TANF consumers. Full implementation of treatment services is to begin statewide by June 15, 1998.

County

Not applicable.

Evaluation Findings

Not applicable.

Other Quantitative Data

None.

HAWAII

OVERVIEW

Hawaii has adopted a statewide managed care strategy that incorporates multiple funding streams. The State's ultimate goal is to establish a single managed health care system for the State's indigent and uninsured residents. Under its Section 1115 waiver, QUEST, general physical health managed care plans provide mental health and substance abuse services to non-SED (severe emotional disturbance) and non-SMI (serious mental illness) individuals. Mental health and substance abuse services for SMI adults and SED children are managed under a separate carve-out arrangement called Community Care Services (CCS). Adults with SMI and children with SED receive their physical health care through the same prepaid health plans that serve the general QUEST population.

Managed Care Programs for Behavioral Health Services

MEDICAID WAIVERS

Section 1115 - Hawaii QUEST - carve-out: For SMI and SED.

MEDICAID VOLUNTARY

Not applicable.

OTHER MANAGED CARE PROGRAMS

Section 1115 - Hawaii QUEST - carve-out: This program serves the non-Medicaid or General Assistance population as well.

Children's Demonstration - behavioral health stand-alone: The Hawaii Child and Adolescent Mental Health Division has implemented a demonstration project on the island of Hawaii in which a single care management company provides behavioral health services to SED children.

Geographic Location

Section 1115 - Hawaii QUEST: Statewide.

Children's Demonstration: Island of Hawaii.

Status of Programs

Section 1115 - Hawaii QUEST: Approved July 16, 1993; implemented August 1, 1994; carve-out for SMI adults began November 1, 1994; carve-out for SED children began September 1, 1997.

Children's Demonstration: Implemented.

Medicaid Substance Abuse Services Remaining Fee-For-Service

Detoxification; outpatient (e.g., intensive outpatient care); inpatient (e.g., hospitalization); rehabilitation (e.g., partial hospitalization, day treatment); opiate treatment.

Medicaid Mental Health Services Remaining Fee-For-Service

Inpatient; outpatient (e.g., clinic services, nonphysician providers); support (e.g., targeted case management); pharmacy.

Medicaid Substance Abuse Services in Managed Care Plan

Section 1115 - Hawaii QUEST: Substance abuse services offered under the general physical health QUEST plans are inpatient (limited to 30 days per benefit year); detoxification (considered part of inpatient benefit); outpatient (limited to 24 hours of visits per benefit year; includes screening for substance abuse problems); opiate treatment; rehabilitation (e.g., individual and group therapy, day treatment, and hospitalization).

Carve-out:

For SMI adults: Inpatient; detoxification (e.g., social and medical); rehabilitation (e.g., individual and group counseling, day treatment and intensive day treatment, prevocational services, social/recreational services); transportation; opiate treatment.

For SED children: Outpatient (e.g., individual and group therapy, group therapy, medication management).

Medicaid Mental Health Services in Managed Care Plan

Section 1115 - Hawaii QUEST: Mental health services offered under the general physical health QUEST plans are inpatient (limited to 30 days per benefit year); outpatient (limited to 24 hours of visits per benefit year; includes psychological testing, partial hospitalization, physician services); crisis (i.e, ambulatory services); prescription drugs (includes medication management, patient counseling); and mental health support (e.g., therapeutic services that include individual and group therapy).

Carve-out:

For SMI adults: Inpatient; crisis; case management; behavioral health treatments (e.g., screening, assessment services, medication evaluation, individual and group counseling, homebound services, continuous treatment teams); day treatment and intensive day treatment; prevocational services; social/recreational services recipient education; transportation services; community education).

For SED children: Outpatient services (e.g., individual and group therapy, psychiatric diagnostic evaluation, individual psychotherapy, group therapy, medication management); inpatient psychiatric facility services (includes 24-hour acute care); targeted case management services.

Non-Medicaid Substance Abuse Services in Managed Care Plan

Section 1115 - Hawaii QUEST: Substance abuse services offered under the general physical health QUEST plans are inpatient; opiate treatment; rehabilitation (e.g., individual and group therapy, day treatment, and hospitalization).

Children's Demonstration: Unknown.

Non-Medicaid Mental Health Services in Managed Care Plan

Section 1115 - Hawaii QUEST: Mental health services offered under the general physical health QUEST plans are inpatient; crisis; day treatment and hospitalization; prescription drugs; physician services; therapeutic services (includes individual and group therapy).

Children's Demonstration: Unknown.

Substance Abuse Prevention and Mental Health Promotion in Managed Care Plan

Section 1115 - Hawaii QUEST: Provider and consumer education; early intervention services; early and periodic screening, diagnosis, and treatment (EPSDT).

Children's Demonstration: Unknown.

Populations Covered Under Managed Behavioral Health

Section 1115 - Hawaii QUEST: Adults and children mandatory: Aid to Families with Dependent Children/Temporary Assistance for Needy Families (AFDC/TANF), former State Health Insurance Program (SHIP) members (persons who may not meet categorical requirements but meet functional requirements—income below 100 percent FPL); U.S. citizen not eligible for insurance through employer, etc.); Supplemental Security Income, dually eligible (Medicare/Medicaid); uninsured (expanded group up to 100 percent FPL meeting asset limits); and underinsured.

Children's Demonstration: SED children who are not covered under Hawaii's QUEST program.

State Managed Care Program Administration

Section 1115 - Hawaii QUEST: Hawaii's Department of Human Services' Med-QUEST Division (Medicaid) contracts with six QUEST health plans for general physical health, including a basic benefit package for mental health and substance abuse. The six plans include two staff models and four preferred provider organization models. All plans must provide services in a managed care environment through a network.

The basic functions or responsibilities of the Medicaid agency include

- Developing and defining the medical, dental, and behavioral health benefits to be provided by the capitated managed care plans;
- Developing the rules, policies, regulations, and procedures to be followed;
- Negotiating and contracting with selected plans;
- Determining the eligibility of recipients;
- Enrolling the recipients into participating plans;
- Monitoring the quality assurance programs of plans and providers;
- Reviewing use of services provided by the plans;
- Handling unresolved recipient grievances with the plans and providers;
- Billing and collecting recipient premium share;
- Monitoring the financial status of QUEST and the Aged, Blind, Disabled (ABD) programs;
- Analyzing the effectiveness of QUEST and the ABD programs in meeting their objectives; and
- Managing the QUEST Information System.

For the behavioral health care carve-out CCS, Medicaid contracts with Hawaii Medical Service Association (HMSA) to deliver specialized mental health and substance abuse services to both SMI adults and SED children. HMSA is also responsible for some physical health services under Hawaii QUEST.

Responsibilities of HMSA include credentialing, provider servicing, care coordination and case management, authorizing services, performing quality assurance and utilization management, claims processing, and contracting with behavioral health care providers. HMSA subcontracts with Hawaii Biodyne and Kapiolani Medical Specialists. Hawaii Biodyne, a for-profit entity under a private, for-profit behavioral health managed care organization, manages the clinical services. Kapiolani Medical Specialists follows Hawaii Biodyne's clinical procedures and criteria to provide utilization management to SED children. Under contract with HMSA, CCS has a comprehensive statewide network of public agencies (e.g., community mental health centers); private entities (e.g., mental health clinics, substance abuse agencies, residential programs for mental health and substance abuse); and psychiatrists and psychologists. The provider panel is open.

Children's Demonstration: Medicaid contracts with a single care management company to administer this program.

Financing of Plans

Section 1115 - Hawaii QUEST: Under QUEST, Hawaii combines into one program three funding sources for health insurance: Medicaid's AFDC-related eligibles; the State funded general assistance program; and SHIP. Funds are blended at the State level in the Medicaid agency's services/benefits budget. The state pays a capitation rate for each QUEST recipient, regardless of the population group.

The six physical health care plans are paid a capitation rate negotiated between the health plans and Medicaid. Most recently, rates were competitively bid. HMSA is at full risk and paid a per-member per-month rate for behavioral health services. Under the carve-out, providers are paid on a fee-for-service or monthly case rate basis (used primarily for case management services). Savings are reinvested in the development of new services. There is a 3 percent limit on profits.

Children's Demonstration: Unknown.

Coordination Between Primary and Behavioral Health Care

Section 1115 - Hawaii QUEST: All participants receive health care through prepaid managed care plans, through which a package of inpatient and outpatient mental health and substance abuse services is available. CCS recipients who meet the criteria for SMI or SED are enrolled in the behavioral health managed care plan and continue to receive their medical and dental care services through the managed care plans.

Children's Demonstration: Under this demonstration, copies of all authorizations are sent to primary care providers (PCPs). Because CCS is an assertive care coordination provider, telephonic links are made with PCPs as necessary.

Consumer-Family Involvement

Section 1115 - Hawaii QUEST: The Behavioral Health Technical Committee, composed of consumers, advocacy organizations, and providers of the multiple subpopulations within the ABD population, met over a 2- to 6-month period to provide input

about the specific behavioral health needs of persons with mental illness, those with substance abuse problems, the aged, persons with developmental disabilities/mental retardation, the homeless, persons with HIV/AIDS, children with behavioral health problems, and persons with multiple diagnoses.

Children's Demonstration: Unknown.

Future Plans

Section 1115 - Hawaii QUEST: Under Phase II, there are plans to expand the populations covered to include the ABD population.

Children's Demonstration: Unknown.

State Agency Administration

The Department of Human Services houses the Med-QUEST Division (Medicaid). The Department of Health houses the Mental Health and Substance Abuse agencies; within each agency resides the Adult and Children and Adolescent Mental Health Division and the Alcohol and Drug Abuse Division, respectively.

Welfare Reform

Hawaii's Welfare to Work (WtW) plan was submitted on January 1, 1998, and approved by the U.S. Department of Labor on March 2, 1998. Hawaii's Department of Labor and Industrial Relations will be administering the grant. One hundred percent of State funds will be used to match Federal dollars. The intended use of 15 percent of the State project funds will be to support innovative approaches to serve special target groups such as substance abusers.

Hawaii requested a waiver for the Department of Labor and Industrial Relations to be the alternate agency to administer the WtW grant funds in three of the four service delivery areas. The substate allocation formula for 85 percent of the funds will be divided in the following ways: 50 percent poor; 25 percent TANF; 25 percent unemployed. Coordination mechanisms linking local WtW entities and local TANF agencies will be defined by private industry councils in local plans. Performance goals and outcome measures include the following:

- Placements in unsubsidized employment;
- Retention and earnings in unsubsidized employment after 13 weeks and up to 1 year;
- Number of individuals receiving post employment services;
- Percentage of those leaving TANF rolls who are employed during the quarter they leave;
- Percentage of those leaving TANF rolls who earn at least the minimum wage 40 hours/week.

Hawaii's welfare reform program currently does not mandate drug testing for all TANF recipients nor does it deny benefits to welfare recipients convicted of drug felonies.

County

Not applicable.

Evaluation Findings

Section 1115 - Hawaii QUEST: The behavioral health carve-out (CCS) has reported the following findings:

- 82.6 percent of CCS members rated care coordination services as excellent or good; and
- Since the inception of the program (1994), HMSA has committed $1.8 million to community infrastructure development to help address shortages of community-based treatment and support.

CCS has a Quality Improvement Committee composed of community representatives who oversee continuous quality improvement. To ensure members receive excellent care, the Committee addresses member needs; ensures that services are being fully utilized; improves the services provided; and incorporates community feedback into service delivery.

Pre-CCS (early 1994) utilization trends were compared with the trends for each year thereafter (1995, 1996, 1997). Quality-of-life measures are being conducted under a SAMHSA grant, in which the SMI population under managed care is being compared to the SMI population whose care is not managed.

Level of functioning and substance use data are currently being collected for an analysis, as of January 1, 1998.

Other Quantitative Data

Section 1115 - Hawaii QUEST: Covers 130,000 lives, which is 80 percent of the Medicaid population. The other 20 percent of Medicaid eligibles (32,000) remain in the fee-for-service system.

IDAHO

OVERVIEW

Idaho's substance abuse authority contracts with a private behavioral health firm for all gatekeeping and support services. The State has recently released a new request for proposals (RFP) for the management and delivery of substance abuse treatment.

Managed Care Programs for Behavioral Health Services

MEDICAID WAIVERS

Not applicable.

MEDICAID VOLUNTARY

Not applicable.

OTHER MANAGED CARE PROGRAMS

Idaho Substance Abuse Services - substance abuse stand-alone: Currently, a managed behavioral health care firm provides support and gatekeeping services on a managed fee-for-service basis.

Geographic Location

Idaho Substance Abuse Services: Statewide.

Status of Programs

Idaho Substance Abuse Services: Currently operating.

Medicaid Substance Abuse Services Remaining Fee-For-Service

The following substance abuse services are covered under Idaho's Medicaid program: inpatient; outpatient (e.g., day care, aftercare); detoxification.

Medicaid Mental Health Services Remaining Fee-For-Service

The following mental health services are covered under Idaho's Medicaid program: inpatient; outpatient; mental health rehabilitation (e.g., targeted case management).

Medicaid Substance Abuse Services in Managed Care Plan

Not applicable.

Medicaid Mental Health Services in Managed Care Plan

Not applicable.

Non-Medicaid Substance Abuse Services in Managed Care Plan

Idaho Substance Abuse Services: Not applicable.

Non-Medicaid Mental Health Services in Managed Care Plan

Idaho Substance Abuse Services: Not applicable.

Substance Abuse Prevention and Mental Health Promotion in Managed Care Plan

Idaho Substance Abuse Services: Not applicable.

Populations Covered Under Managed Behavioral Health

Idaho Substance Abuse Services: Children and adults mandatory: uninsured.

State Managed Care Program Administration

Idaho Substance Abuse Services: The Department of Health and Welfare contracts with a private managed behavioral health care firm to provide support and gatekeeping services for substance abuse treatment in each of the State's three Integrated Service Areas. The firm is not at risk and receives a set fee for services rendered.

Financing of Plans

Idaho Substance Abuse Services: The behavioral health care firm receives a set fee for services rendered.

Coordination Between Primary and Behavioral Health Care

Idaho Substance Abuse Services: Not applicable.

Consumer-Family Involvement

Idaho Substance Abuse Services: Unknown.

Future Plans

★ *New Program Under Development:* The State has released an RFP to contract out substance abuse services, including prevention services, day care, aftercare, outpatient, inpatient, and detoxification. The program will cover uninsured children and adults who will be required to pay for services on a sliding scale. Firms responding to the RFP may or may not subcontract out the services to providers.

State Agency Administration

The Medicaid authority, the Division of Medicaid, is within the Department of Health and Welfare, as is the mental health and substance abuse authority, the Bureau of Mental Health and Substance Abuse Services.

Welfare Reform

Idaho's statewide Temporary Assistance for Needy Families program became effective July 1, 1997. The program denies benefits to drug felons but does not test recipients for drug use.

County

Not applicable.

Evaluation Findings

Not applicable.

Other Quantitative Data

Not applicable.

ILLINOIS

OVERVIEW

Illinois has no immediate intention of developing a managed care plan specifically for publicly funded behavioral health care. However, the State operates a voluntary managed care program for physical health that includes all mental health and substance abuse services covered by the Medicaid program. The voluntary program is called Responsible Choice and requires all clients to make a choice between the fee-for-service (FFS) program and the managed care program. Services under the managed care program are delivered by health maintenance organizations (HMOs) and prepaid health plans (PHPs). PHPs are HMO-like entities that are non-risk bearing entities regulated by the Illinois Department of Public Aid (IDPA). Both medical assistance grant (MAG) cases and medical assistance no grant (MANG) eligibles are allowed to enroll in managed care.

Managed Care Programs for Behavioral Health Services

MEDICAID WAIVERS

Illinois was granted a Section 1115 waiver in July 1996. At the current time, the State has chosen not to implement the waiver program.

MEDICAID VOLUNTARY

Responsible Choice - general health - integrated: Voluntary program that includes all mental health and substance abuse services covered by the Medicaid program.

OTHER MANAGED CARE PROGRAMS

Not applicable.

Geographic Location

Responsible Choice: Currently implemented in Cook and St. Clair Counties. Contracts are in place under the voluntary program to cover 67 counties.

Status of Programs

Responsible Choice: Implemented in January 1975 in two counties. Contracts expanded to cover 45 counties in December 1997. Sixty-seven counties covered by contract in May 1998.

Medicaid Substance Abuse Services Remaining Fee-For-Service

Outpatient; acute detoxification; residential substance abuse treatment programs.

Medicaid Mental Health Services Remaining Fee-For-Service

Inpatient; Institution for Mental Diseases (IMD) services for individuals under age 22 and over age 65; outpatient; mental health rehabilitation.

Medicaid Substance Abuse Services in Managed Care Plan

Responsible Choice: Crisis (e.g., emergency care services, crisis assessment and intervention); outpatient (e.g., psychiatric evaluation); detoxification services.

Medicaid Mental Health Services in Managed Care Plan

Responsible Choice: Inpatient; IMD services for individuals under age 22 and over age 65; outpatient; mental health rehabilitation.

Non-Medicaid Substance Abuse Services in Managed Care Plan

Not applicable.

Non-Medicaid Mental Health Services in Managed Care Plan

Not applicable.

Substance Abuse Prevention and Mental Health Promotion in Managed Care Plan

Responsible Choice: No preventive behavioral health services are offered.

Populations Covered Under Managed Behavioral Health

Responsible Choice: Children and adults voluntary: Temporary Assistance for Needy Families (TANF) MAG and MANG recipients. Children voluntary: general assistance.

State Managed Care Program Administration

Responsible Choice: IDPA currently contracts with ten HMOs and six PHPs. All Medicaid covered behavioral health care services must be provided by the managed care entities.

Performance of administrative functions varies from HMO to HMO. Some HMOs contract out for these services while others do not.

Financing of Plans

Responsible Choice: The voluntary program is financed with Medicaid funds. The managed care entities are paid a capitated rate. The payment rate was determined by pulling FFS claim information for a specific fiscal year and dividing by member months for the same period. The resulting rate was inflated to the contract rate year with a 5 percent reduction applied to determine the capitation rate. On average in Cook County, the Aid to Families with Dependent Children (AFDC) MAG rate is $103.00 and the AFDC MANG rate is $173.00. On average, the statewide rate for AFDC MAG is $103.00 and the AFDC MANG rate is $167.00. Mental health and substance abuse payments are included in the capitation rate.

IDPA's contracted HMOs are at full risk while the PHPs are non-risk-bearing entities. PHPs are paid a capitation rate but revenues and expenses are periodically reconciled to the FFS equivalents so as to eliminate risk.

Coordination Between Primary and Behavioral Health Care

Responsible Choice: Meetings are held regularly with representatives of community behavioral health providers, the managed care plans and their behavioral health subcontractors, IDPA, and Offices of Mental Health and Alcohol and Substance Abuse within the Department of Human Services (DHS). These meetings focus on an array of issues pertaining to behavioral health care, including coordination of care between the plans, the behavioral health providers, and the primary care physicians.

Consumer-Family Involvement

Responsible Choice: Illinois extensively used focus groups of clients to obtain feedback on the effectiveness of information used to explain the voluntary managed care program to clients. These focus groups have been conducted throughout the state and with representative groups of the Medicaid population including persons with mental illness or receiving treatment for substance abuse. The feedback has been useful in the development of client education materials.

Future Plans

Responsible Choice: Expansion of the voluntary managed care program to additional counties is a goal of the program. DHS is willing to expand the program into any county a managed care entity is able to serve as long as a sufficient network of providers exists to serve the population.

A primary care case management (PCCM) option exists in the second year of the Responsible Choice program. At this time, no decision has been made whether a PCCM system will be implemented.

★ *New Program Under Development:* Services to Children with Serious Emotional Disorders Initiative: A proposal has been drafted for a statewide project that would provide foster care/

kinship and residential care to children with severe emotional disorders in State custody.

State Agency Administration

The Medicaid authority is the Office of Medical Programs, within IDPA. The mental health authority is the Office of Mental Health and Developmental Disabilities within DHS. The substance abuse authority is the Office of Alcoholism and Substance Abuse, within DHS.

Welfare Reform

The State's TANF plan went into effect July 1, 1997. It denies benefits to drug felons but does not test recipients for drug use.

The State submitted a Welfare-to-Work grant to the Department of Labor on December 12, 1997. It was approved January 29, 1998. One hundred percent of matching funds are State dollars. Fifty percent of the substate allocation goes to poor individuals, and fifty percent to TANF recipients.

County

Not applicable.

Evaluation Findings

IDPA is in the process of developing a request for proposal (RFP) from Quality Assurance Organizations (QAOs) to review access and quality of managed care services. The QAO RFP is expected to be released during the summer of 1998.

IDPA is currently working with all of the managed care entities under contract to develop a uniform satisfaction survey for clients. The survey will assist the Department with assessing from the client's perspective the quality of services provided by the managed care entities.

Other Quantitative Data

Not applicable.

INDIANA

OVERVIEW

Indiana's Medicaid mandatory managed care program for low-income pregnant women and children and families includes behavioral health as a self-referral service. The State operates one voluntary Medicaid program that offers some behavioral health services. In addition, two non-Medicaid programs are specific to behavioral health care. The Hoosier Assurance Plan is a risk-sharing managed care system for non-Medicaid public behavioral health care services. The Dawn Project is operated at the county level and financed by State and local agencies.

Managed Care Programs for Behavioral Health Services

MEDICAID WAIVERS

Not applicable.

MEDICAID VOLUNTARY

Hoosier Healthwise for Persons with Disabilities and Chronic Illness (HHPD) - general health - integrated: Voluntary risk-based program; no waiver required.

OTHER MANAGED CARE PROGRAMS

Hoosier Assurance Plan - general assistance - behavioral health stand-alone: Funded by Federal block grants and State general fund dollars; serves people with mental illnesses, emotional disorders, and chemical addictions.

The Dawn Project - behavioral health stand-alone: A pilot project run by Marion County and financed by blended funds from the State and local agencies.

Geographic Location

HHPD: Marion County.
Hoosier Assurance Plan: Statewide.
The Dawn Project: Marion County

Status of Programs

HHPD: Implemented July 1997.
Hoosier Assurance Plan: Currently being phased in.
The Dawn Project: Implemented May 1, 1997.

Medicaid Substance Abuse Services Remaining Fee-For-Service

Inpatient service; outpatient substance abuse; detoxification; opiate treatment programs; residential substance abuse treatment programs.

Medicaid Mental Health Services Remaining Fee-For-Service

Inpatient hospital services; outpatient hospital services (including clinic services); Institution for Mental Diseases (IMD) services (e.g., inpatient psychiatric specialty hospitals for individuals age 65 and over or age 21 and under); mental health rehabilitation services (e.g., targeted case management).

Medicaid Substance Abuse Services in Managed Care Plan

HHPD: The following substance abuse services are covered under Indiana's Medicaid program: inpatient service; outpatient substance abuse; detoxification; opiate treatment programs; residential substance abuse treatment programs.

Medicaid Mental Health Services in Managed Care Plan

HHPD: Inpatient hospital services; outpatient hospital services (including clinic services); IMD services (e.g., inpatient psychiatric specialty hospitals for individuals age 65 and over or age 21 and under); mental health rehabilitation services (e.g., targeted case management).

Non-Medicaid Substance Abuse Services in Managed Care Plan

Hoosier Assurance Plan: Outpatient substance abuse services (e.g., individualized treatment planning to increase patient coping skills and symptom management); crisis; inpatient services (e.g., acute stabilization services); detoxification. There are 30 mental health plans and 29 addiction plans under the Hoosier Assurance Plan. The addiction plans deal with detoxification differently.

The Dawn Project: Substance abuse services for children include outpatient; rehabilitation (e.g., intensive case management); crisis; detoxification; inpatient. The program addresses the need for substance abuse services for the parents as well. The Dawn Project typically does not pay for substance abuse services for the parents; however, they are referred to treatment and receive case management services.

Non-Medicaid Mental Health Services in Managed Care Plan

Hoosier Assurance Plan: Mental health rehabilitation (e.g., individualized treatment, coping skills); crisis (e.g., 24-hour-a-day intervention); outpatient services (e.g., intensive outpatient services, counseling, and treatment); inpatient services.

The Dawn Project: Mental health rehabilitation (e.g., intensive case management); crisis (e.g., crisis intervention); outpatient; inpatient; mental health residential; mental health support (e.g., mentoring, respite care, and help with basic needs to support families to function).

Substance Abuse Prevention and Mental Health Promotion in Managed Care Plan

HHPD: Not applicable.

Hoosier Assurance Plan: Prevention is funded by the Division of Mental Health (DMH) outside of the treatment plans.

The Dawn Project: The target population for the Dawn Project is children who are at imminent risk of out-of-home placement because of a serious emotional disturbance, and thus are well beyond prevention. However, the goal is that as savings are realized from this population, the savings will be used to serve children whose problems are less serious. Funding prevention was not a goal for this program.

Populations Covered Under Managed Behavioral Health

HHPD: Children and adults voluntary: Supplemental Security Income (SSI). HHPD does not cover individuals being served by the Hoosier Assurance Plan.

Hoosier Assurance Plan: Children and adults voluntary: Aid to Families with Dependent Children/Temporary Assistance for Needy Families (AFDC/TANF), SSI, Seventh Omnibus Budget Reconciliation Act (SOBRA), uninsured, and underinsured. The program defines uninsured as individuals living at or below 200 percent of the Federal poverty level.

The Dawn Project: Children voluntary: SSI.

State Managed Care Program Administration

HHPD: The Medicaid agency provides the funding for this program and contracts with managed care organizations (MCOs).

Hoosier Assurance Plan: The DMH contracts with not-for-profit community mental health centers (CMHCs) and freestanding addiction providers. These nonprofit organizations behave as limited health maintenance organizations (HMOs) and are at full risk for DMH-funded services.

The Dawn Project: The three agencies that blend their funding are the Marion County Office of Family and children; the Department of Education, Special Education Division; and the Family and Social Services Administration (FSSA) DMH. DMH and Special Education each have a memorandum of understanding with Marion County through which they provide funding to Marion

County. Marion County is the entity that contracts with the MCO. The MCO then contracts with various providers to provide the needed services. The provider network is open. Because the project has been in place only one year, the MCO was not really at full risk. However, the MCO will be at risk during the second year and the terms for that risk are presently being negotiated by the payers and the MCO.

Financing of Plans

HHPD: The MCO is at full risk for all Medicaid-covered mental health services.

Hoosier Assurance Plan: Financed by Federal block grants and State general fund dollars. Funds are allocated directly to geographic regions of the State based on the percentage of the at-need population residing in the area. Managed Care Plans are funded by blended Federal and State dollars on a case rate basis.

The Dawn Project: Funding comes from blending funds from the Indiana Family and Social Services Administration, the Department of Education, the Marion County Office of Family and Children, Marion Superior Court, and the Mental Health Association Marion County. The providers are paid by the MCO. The MCO is paid a capitated rate on a monthly basis for each child enrolled in the program that month. The rate was established by the Consortium for the project after review of available data on children who were in placement.

Coordination Between Primary and Behavioral Health Care

HHPD: The HHPD program encourages communication between mental health providers and the enrollee's primary medical provider even though mental health services can be accessed on a self-referral basis.

Hoosier Assurance Plan: Hoosier Assurance Plan providers receive much of their funding in fee-for-service medical environment and are responsible for coordinating care.

The Dawn Project: Each child has an annual well-child check and a primary care physician is identified. For Medicaid-eligible children, early and periodic screening, diagnosis, and treatment (EPSDT) is available.

Consumer-Family Involvement

HHPD: The Family and Social Services Administration/Office of Medicaid Policy and Planning spent over a year analyzing utilization, eligibility, and diagnosis data for the populations and consulted with more than 20 advocacy groups and other State agencies serving persons with disabilities.

Hoosier Assurance Plan: The Indiana Family and Social Services Administration/DMH is advised by a council and five bureau committees, all of which include consumer representatives of the targeted populations. The targeted populations are adults with serious mental illness (SMI), children and adolescents with severe emotional disturbance (SED), and persons of all ages with chronic addictive disorders. The committees and the council have provided input into the design and implementation of the Hoosier Assurance Plan since its inception and continue to do so.

The Dawn Project: Parents of children with SED are members of the Consortium and served on the task force that developed the name of the project and the parents' handbook. Parents also advised as to what type of group they wanted to form among themselves. Parents and sometimes older children are also part of the service coordination team, and no meetings are held unless the parents are present.

Future Plans

HHPD: The program may expand to include dually eligibles.

Hoosier Assurance Plan: The next step is to develop risk-adjusted rates for all populations and provide choice to persons with SMI.

The Dawn Project: The State is evaluating how it could help provide the infrastructure for other counties to implement their version of a "Dawn-like" project. DMH is contracting with local prevention service coalitions. The Dawn Project is similar to the Hoosier Assurance Plan in that a capitated rate is paid for an episode of services. The data and enrollment requirements are different, but pre- and post-tests are administered to measure impact.

State Agency Administration

The substance abuse and mental health authorities are both within the DMH, which is housed along

with the Office of Medicaid Policy and Planning in FSSA.

Welfare Reform

The State's TANF plan became effective in October 1996. The plan denies TANF benefits to drug felons but does not perform drug testing on eligibles.

Child Welfare Demonstration Project: Provides traditional child welfare services as well as wraparound services for multisystem children and the Healthy Families Indiana services, which provides home visitations for infants at risk in overburdened families. Child welfare, mental health, Medicaid, education, and juvenile justice all contribute funding to this project.

County

Not applicable.

Evaluation Findings

Hoosier Assurance Plan: Studies are currently under way.

The Dawn Project: The impact on cost is being evaluated now that some children are "graduating" from the program.

Other Quantitative Data

The Dawn Project: Present enrollment: 116 children.

IOWA

OVERVIEW

Iowa has two managed behavioral health care methods for Medicaid recipients: A statewide mental health stand-alone (Mental Health Access Plan—MHAP) and a statewide substance abuse stand-alone (Iowa Managed Care Substance Abuse Care Plan—IMSACP). Recently, the Department of Human Services and Department of Public Health awarded a contract to a private, for-profit behavioral health managed care organization (BHMCO) to manage the substance abuse and mental health programs under a single managed behavioral health care program. For the non-Medicaid population and services, Iowa's 99 counties have been required by State statute to develop county management plans to guide the expenditure of county and State funds.

Managed Care Programs for Behavioral Health Services

MEDICAID WAIVERS

Section 1915(b) - MHAP - mental health stand-alone.
Section 1915(b) - Iowa Managed Substance Abuse Care Plan (IMSACP) - substance abuse stand-alone.

MEDICAID VOLUNTARY

Not applicable.

OTHER MANAGED CARE PROGRAMS

County Program - mental health stand-alone: Iowa's 99 counties have established their own mental health managed care plan for non-Medicaid beneficiaries or services. In addition, four counties were approved as adult decategorization demonstration sites to explore the feasibility of blending mental health funds into a single funding stream for the provision of mental health services.

Geographic Location

Section 1915(b) - MHAP: Statewide.
Section 1915(b) - IMSACP: Statewide.
County Program: Statewide by county.

Status of Programs

Section 1915(b) - MHAP: Submitted April 1994; approved June 6, 1994; implemented March 1, 1995.

Section 1915(b) - IMSACP: Submitted April 1995; approved July 13, 1995; implemented September 1, 1995.

County Program: Legislation passed in 1996 mandated that each of the State's 99 counties establish its own mental health managed care plan for non-Medicaid beneficiaries or services. This program has been implemented in all 99 counties.

Medicaid Substance Abuse Services Remaining Fee-For-Service

Inpatient, outpatient, acute detoxification.

Medicaid Mental Health Services Remaining Fee-For-Service

Inpatient; mental health support (e.g., targeted case management); pharmacy; outpatient (e.g., clinic services, nonphysician providers); residential (e.g., home health); Institution for Mental Diseases services for those under age 21.

Medicaid Substance Abuse Services in Managed Care Plan

Section 1915(b) - MHAP: Counseling services provided only to dually diagnosed individuals.

Section 1915(b) - IMSACP: Inpatient; acute detoxification (e.g., inpatient hospital); residential

(e.g., medically monitored, primary, extended, halfway house); outpatient (e.g., intensive, extended individual, family, group).

Three facilities (House of Mercy in Des Moines, Heart of Iowa-ASAC in Cedar Rapids, and St. Luke's Gordon Recovery Center in Sioux City) provide a comprehensive array of substance abuse treatment and related services referred to as Women and Children Programs. As of December 1996, services provided by these programs are funded through a combination of IMSACP Medicaid and IMSACP non-Medicaid funding.

Women and Children Programs: Supportive assistance for pregnant women and substance abusing women with dependent children in addition to other clinical and supportive services, residential, and transportation.

Medicaid Mental Health Services in Managed Care Plan

Section 1915(b) - MHAP: Inpatient; outpatient (e.g., subacute care, 24-hour observation, partial hospital, day treatment, psychiatric physician services, psychologist and social worker services, community mental health centers); support (e.g., targeted case management, community-support programs, assertive community treatment); crisis (e.g., crisis, mobile counseling, 24-hour crisis including a toll-free hotline, respite services); residential (e.g., crisis stabilization beds).

Section 1915(b) - IMSACP: Women and Children Programs: Outpatient.

Non-Medicaid Substance Abuse Services in Managed Care Plan

County Program: Not applicable.

Non-Medicaid Mental Health Services in Managed Care Plan

County Program: Range of services varies by county. Counties are required to provide funding for inpatient services at the State mental health institutes, and to contract for community mental health services such as outpatient and community support. In addition, many counties provide a range of supportive services, such as case management, residential care, treatment, and some level of employment support.

Substance Abuse Prevention and Mental Health Promotion in Managed Care Plan

Section 1915(b) - MHAP: Enrollee education; public education (limited).

Section 1915(b) - IMSACP: Enrollee education.

County Program: Public information. In addition, as part of counties' contracts with mental health centers, some counties have historically funded some activities such as crisis counseling in schools where a suicide has occurred, or other prevention programs.

Populations Covered Under Managed Behavioral Health

Section 1915(b) - MHAP: Mandatory adults and children: Aid to Families with Dependent Children/Temporary Assistance for Needy Families (AFDC/TANF); Supplemental Security Income (SSI); dually eligible (Medicaid/Medicare); pregnant women, up to 185 percent Federal poverty level (FPL); infants under 1 year (up to 185 percent FPL); children age 1–5 (up to 133 percent FPL); children age 6–18 (up to 133 percent FPL).

Section 1915(b) - IMSACP: Mandatory adults and children: AFDC/TANF; SSI; dually eligible (Medicaid/Medicare); pregnant women (up to 185 percent); infants under 1 year (up to 185 percent FPL); children age 1–5 (up to 133 percent FPL); children age 6–18 (up to 133 percent FPL).

County Program: Adult consumers of public mental health and/or mental retardation services. Eligibility criteria vary by county and are required to be identified in the county management plans. Eligibility is based on a combination of diagnosis and financial need. There is a broader mandate for counties to serve persons with mental retardation. In some instances, eligibility can also vary by service. Most counties have lower eligibility criteria for funding mental health crisis services than for those services considered to be more discretionary.

State Managed Care Program Administration

Section 1915(b) - MHAP: Iowa's Department of Human Services (DHS) contracts with a private, for-profit BHMCO to provide comprehensive mental health services and related substance abuse services. The State's responsibilities include monitor-

ing the financial status, administrative procedures, and quality of care delivered by the mental health managed care plan.

BHMCO responsibilities include network management, claims payment, utilization review, prior authorization, quality assurance, data report generation, joint treatment planning, crisis counseling, and development of new treatment modalities.

The BHMCO contracts with an open panel of clinicians (e.g., any willing provider of mental health services). Additionally, the BHMCO contracts with community mental health centers.

Section 1915(b) - IMSACP: Iowa Department of Public Health and Iowa DHS contract with a single not-for-profit agency as the primary contractor for Medicaid and public health populations. For the Medicaid population, the managed care organization (MCO) formed a public/private partnership through a subcontract with a private for-profit BHMCO (the same BHMCO operating the MHAP) to provide clinical and administrative services for the Medicaid population.

For Medicaid, the open provider network consists of freestanding facilities, hospitals with substance abuse treatment units (inpatient or outpatient), and community-based providers. This network has more than tripled since the introduction of managed care. For non-Medicaid, the MCO contracts with approximately 35 community-based providers and approximately 15 hospital-based providers.

The MCO is responsible for overseeing performance for Medicaid and non-Medicaid under the IMSACP contract. For the Medicaid population, the subcontractor is responsible for data collection, provider relations, quality management, provider contracting, and payment and claims processing. For the non-Medicaid population, the providers are responsible for network development and service delivery.

County Program: Iowa State legislation requires each county to manage its services and funds for persons with mental health, mental retardation, and developmental disabilities through a central point of coordination (CPC). There are a number of different models that counties have employed for managing this system, including contracting with an MCO (Cerro Gordo County), contracting with another management entity (a number of counties in south central Iowa and Woodbury), and 28E agreements between counties to share management staff. In all other counties, the CPC is responsible for prior authorization/gatekeeping.

Through the planning process, each county has determined the provider network. In most counties, this network is open and based on historical use. However, some counties have chosen not to contract with certain providers, usually where there is a question of the quality of care or a conflict over accountability. Providers primarily provide the direct services and may also have been designated as an "access point" to begin gathering the information for the CPC application.

In Polk County, Polk County Health Services (PCHS), a nonprofit corporation, administers the mental health/mental retardation/developmental disabilities (MH/MR/DD) program and serves as the CPC. PCHS is the manager of the demonstration project and contracts with four lead agencies in the demonstration. The lead agencies are nonprofit entities, a consortium of providers, who contract to provide all services necessary for their enrollees.

Financing of Plans

Section 1915(b) - MHAP: Iowa's DHS contracts with a private, for-profit BHMCO on a prepaid capitated basis. MHAP fully capitates the provision of mental health services through the BHMCO, including claims payment and other administrative costs. The capitation rate has been set at 86 percent of the cost of Iowa's fee-for-service (FFS) program and contains a cost sharing provision. Some service dollars (about $1 million per year) are reinvested in community-based care to target high users of mental health services. The funds that remain after direct service provision and reinvestment are divided between the State and MCO, 80 percent and 20 percent, respectively. The BHMCO is at full risk. Providers are paid on a negotiated FFS basis. DHS requires the BHMCO to negotiate with any county that wishes to blend its funds with the Medicaid funds administered by the BHMCO. To date, only one county has blended its funds with the BHMCO.

Section 1915(b) - IMSACP: The existing statewide substance abuse carve-out has several unique features. The plan integrates the administration of substance abuse funds that were previously allocated to

two different agencies, DHS for Medicaid and the Department of Public Health for the SAMHSA block grant. Funding streams for the Medicaid and public health populations remain separate. Integration occurs at the contracting/administrative level. The BHMCO is at full risk for the Medicaid population. DHS established a capitation rate for Medicaid based on a percentage of the base year (1994) FFS cost. The State took savings off the top by setting the maximum at 86 percent of the upper payment limit. No state-ensured stop-loss protection is provided. Providers bill the BHMCO on a claims basis.

IMSACP providers serve eligible non-Medicaid clients on a standardized sliding-scale fee basis, based on income and family size. For the State-only public health populations, the substance abuse treatment providers are at risk. Substance abuse treatment providers receive a monthly allocation from Employee and Family Resources (EFR) to provide services to the non-eligible Medicaid population.

County Program: Four of Iowa's 99 counties (Polk, Tama, Poweshiek, and Linn) are approved as demonstration sites to blend mental health funding streams, including Medicaid funds. The legislature directed DHS and vocational rehabilitation to work with the four adult decategorization counties to participate in the county planning process to determine the feasibility of decategorizing State, Federal, and county funds.

The county MH/MR/DD services fund is used to pay for MH/MR/DD services for non-Medicaid individuals and for services not covered by Medicaid. The MH/MR/DD services fund is composed of county property tax levy funds, State appropriations for property tax relief, Social Services block grant funds and State appropriations for MH/DD community services fund. An established payment rate per person is paid to the lead provider in each county. Polk County has established a pilot project to explore an alternative funding mechanism. PCHS acts as the repository for all county-controlled mental health funds and deducts off the top of the rate money for administrative expenses and for an incentive fund and risk pool. PCHS then pays the lead agencies in advance according to the number of consumers enrolled.

Polk County funds are the sole source of funding for the demonstration. There is a single rate for MR/DD enrollees ($9,177/year) and a single rate of $8,111/year for enrollees with severe and persistent mental illness. PCHS removes 8 percent off the top using 2.5 percent for training expenses, 2.5 percent for a risk pool, and 3 percent for an incentive fund. If the agency qualifies for incentive funds at the end of the year, by virtue of a good grade on its evaluation, then it receives those funds to use at its discretion for the benefit of enrollees in the project.

In the other 98 counties, counties contract for services on a FFS basis. A few counties continue to fund community mental health centers on a block grant basis, however. Since the passage of Senate File 69, most counties are working on increasing the accountability of providers for the expenditure of county funds.

Coordination Between Primary and Behavioral Health Care

Section 1915(b) - MHAP: For both carve-out waivers, coordination is handled in the same manner. The MHAP contractor is required to establish linkages with health maintenance organizations (HMOs) and the IMSACP contractor to ensure that client services are coordinated when those services require coordination among plans. The medical care home base for clients in the carve-out waivers varies. Some clients are served through the FFS Medicaid program, which means that care may be delivered by a variety of Medicaid providers.

Section 1915(b) - IMSACP: For both carve-out waivers, coordination is handled in the same manner. The IMSACP contractor is required to establish linkages with HMOs and the MHAP contractor to ensure that client services are coordinated when those services require coordination among plans. The medical care home base for clients in the carve-out waivers varies. Some clients are served through the FFS Medicaid program, which means that care may be delivered by a variety of Medicaid providers.

County Program: There is no formal coordination of physical and mental health services under the county program. County funding of physical health care is fairly limited. Some coordination may be

provided by the case manager, county social worker, or provider agency.

Consumer-Family Involvement

Section 1915(b) - MHAP: Statewide contractor conducts monthly consumer roundtables. The purpose of the consumer roundtables is to serve as a forum for discussion and exchange of information on new policies, to receive input and hear concerns. Performance indicators are designed by a subcommittee of the Council on Human Services and by the MHAP team which includes two consumers. The roundtables are conducted by the MHAP contractor and focus on the current MHAP contract. The roundtables have resulted in policy changes, consumer newsletter editing, and discussion of satisfaction survey findings. These consumer roundtables also supported the MCO's decision to hire a part-time consumer representative and family member representative.

Iowa's DHS services released a request for information (RFI) to solicit ideas about MHAP for year 3 of the carve-out from the stakeholder community (consumers, providers). Most importantly, the feedback from the RFI process has laid a foundation for the future of the MHAP. Responses to the RFI were received from the stakeholder community, including consumers, providers, and counties. Information was requested in three areas: performance indicators which might be used to assess the impact of MHAP; suggestions about changes in the design of MHAP for the future; and comments about the Consumer-Oriented Mental Health Report Card developed by a national committee working with the Center for Mental Health Services, SAMHSA.

Section 1915(b) - IMSACP: Provider and corrections groups and minority representatives/advocates provided input in the implementation of the waiver. After implementation, Iowa State University conducted an independent assessment and surveyed consumers to evaluate consumer satisfaction in 1996 and again in 1997. The area of substance abuse treatment does not have strong consumer advocates; therefore, providers tend to advocate for their clients.

County Program: Counties were required to involve consumers and families in the development of the individual county plans.

Future Plans

Section 1915(b) - MHAP: Will be subsumed under new integrated managed care program in January 1999.

Section 1915(b) - IMSACP: Will be subsumed under new integrated managed care program in January 1999. A second evaluation (see the Evaluation Findings Section) will be released September 1998.

County Program: During the 1998 session, the Iowa Legislature passed a bill establishing some different financing methodologies: per capita expenditure allocation, incentive and efficiency allocation, and a risk pool. It is anticipated that financing of the system will continue to evolve over the next few years. Additionally, counties continue to work on contracting and rate-setting methodologies with providers.

★ *New Program Under Development:* Iowa released its third and final draft entitled the Iowa Plan for Behavioral Health (Iowa Plan) in March. Primary responsibility of the plan will rest with DHS and the Department of Public Health who will provide monitoring of the ultimate contract. Pre-implementation of this program will begin July 1, with the contract beginning on January 1, 1999. The plan integrates Medicaid, mental health, substance abuse, and State/Federal substance abuse treatment services under a single statewide contractor or multiple regional contractors. The contractor will develop a regional provider network in order to decentralize the Iowa Plan. Consumers and families will participate on the Iowa Plan Advisory Committee. This program will serve all populations currently served by MHAP and IMSACP.

State Agency Administration

Medicaid and Mental Health are housed under DHS. Medicaid is within DHS' Division of Medical Services, while Mental Health is in DHS' Division of Mental Health/Developmental Disability. Substance Abuse is in the Division of Substance Abuse and Health Promotion under the Iowa Department of Public Health.

Welfare Reform

Iowa's welfare reform plan provides parenting classes for welfare recipients under age 18 who are

required to participate. The classes are conducted as a component of the substance abuse prevention programs. They are cofunded by State agencies, including the Alcohol and Other Drug Department and the Work Force Development Department. Additionally, Iowa does not mandate drug testing to TANF recipients; any TANF eligible convicted of a drug-related felony will be required to participate satisfactorily in a rehabilitation program or meet other requirements to demonstrate he or she isn't using or possessing controlled substances.

County

Described under "County Program" throughout profile.

Evaluation Findings

Section 1915(b) - MHAP: In the first contract year, the following outcomes were discovered from the period prior to implementation to year 1 to year 2 of the waiver:

- Average length of stay decreased from 11.8 days to 6 days in year 1 to 5 days in year 2.
- Readmits to inpatient hospitals increased from 25.5 percent to 29.5 percent in year 1 to 24.6 percent in year 2.
- Under the private, for-profit MCO's reinvestment program, 30 special projects were funded.

Section 1915(b)-IMSACP: An independent assessment evaluating the impact of managed care on substance abuse was completed in June 1997 by Iowa State University. The assessment found

- The number of inpatient claims and lengths of stay for inpatient episodes dropped;
- The number of clients served primarily in outpatient services greatly increased;
- IMSACP clients were more likely than FFS clients to be continuing substance use;
- Satisfaction remained high and was not significantly different from the FFS system or from other medical services received under Medicaid; and
- Generally the focus groups indicated that IMASCP had increased the range and proximity of services, broadened the client base, implemented improved assessment criteria, and developed good pilot programs.

Other Quantitative Data

Not applicable.

KANSAS

OVERVIEW

Kansas does not manage behavioral health services under Medicaid. However, using State revenue dollars and Federal block grants, the Alcohol and Drug Abuse Services (ADAS) Division, located within the Department of Social and Rehabilitation Services (SRS), operates an Alcohol and Drug Managed Care Model. This statewide managed care program provides capitated substance abuse prevention and treatment services. Mental health services remain in the fee-for-service system.

Additionally, SRS has privatized child welfare services and operates a family preservation, foster care, and adoption managed care project through a public/private partnership.

Managed Care Programs for Behavioral Health Services

MEDICAID WAIVERS

Not applicable.

MEDICAID VOLUNTARY

Not applicable.

OTHER MANAGED CARE PROGRAMS

Alcohol and Drug Managed Care Model - substance abuse stand-alone: substance abuse services: Regional assessment centers form the core of the system and refer clients for appropriate treatment after an initial assessment.

Children and Family Services (CFS) Privatization - integrated: Kansas is the first state to privatize the administration and delivery of child welfare services. In two of the five child welfare regions, a public/private partnership delivers family preservation services, adoption services and foster/group care while nonprofit providers provide services in the remaining three regions.

Geographic Location

Alcohol and Drug Managed Care Model: Statewide.

CFS Privatization: Statewide.

Status of Programs

Alcohol and Drug Managed Care Model: Implemented in three phases. A pilot with treatment funds only was implemented in the Wichita/Hutchinson region in 1995–96. Statewide implementation began in fall 1996 for both prevention and treatment services. Federal block grant set-asides are tracked through the contracts and the management information outcome system.

CFS Privatization: First year contracts ran from February 1, 1997 to January 31, 1998.

Medicaid Substance Abuse Services Remaining Fee-For-Service

Inpatient, outpatient, crisis, detoxification, residential.

Medicaid Mental Health Services Remaining Fee-For-Service

Inpatient, outpatient, mental health support, mental health rehabilitation, crisis, Institution for Mental Diseases services for individuals over age 65 and under age 21.

Medicaid Substance Abuse Services in Managed Care Plan

Not applicable.

Medicaid Mental Health Services in Managed Care Plan

Not applicable.

Non-Medicaid Substance Abuse Services in Managed Care Plan

Alcohol and Drug Managed Care Model: Detoxification, outpatient, residential.

CFS Privatization: Not applicable.

Non-Medicaid Mental Health Services in Managed Care Plan

Alcohol and Drug Managed Care Model: Not applicable.

CFS Privatization: Inpatient, crisis, mental health support, outpatient, mental health rehabilitation.

Substance Abuse Prevention and Mental Health Promotion in Managed Care Plan

Alcohol and Drug Managed Care Model: Prevention services are focused on 13 regional prevention centers that facilitate a community development/mobilization process to reduce risk and increase protective factors.

CFS Privatization: Crisis services are available to preserve the family and prevent out-of-home placements for the child(ren).

Populations Covered Under Managed Behavioral Health

Alcohol and Drug Managed Care Model: Voluntary adults and children: The focus is on those who meet federal poverty guidelines (200 percent of Federal poverty level) which includes those formerly or currently on Supplemental Security Income.

CFS Privatization: The children served by the CFS contractors fit within several categories. Some of the children are designated as "children in need of care;" some meet Medicaid eligibility guidelines; some are in the custody of the Secretary of SRS; and some may be juvenile offenders.

State Managed Care Program Administration

Alcohol and Drug Managed Care Model: There are many partners and stakeholders in the Kansas Alcohol and Drug Managed Care framework, including providers, consumers, and citizens. The managed care framework, however, is predicated upon specific roles for three entities—SRS/ADAS, the Regional Alcohol and Drug Assessment Centers (RADACs), and the management organization. The system design deliberately separates administrative and clinical decisions.

The State provides leadership for the managed care infrastructure. The State's primary role is to communicate State policy, program direction, and desired outcomes regarding prevention and treatment to the contractors; to evaluate program and service effectiveness; to evaluate program and RADAC data to identify gaps in services; and to monitor the performance of the management organization and the RADACs.

The State's clinical partners, the RADACs, are the driving force of the treatment system. Their primary role is to provide a central point of entry to substance abuse treatment services, including determination of financial eligibility, clinical assessment for substance abuse including use of the Kansas Client Placement Criteria and referral to an appropriate substance abuse treatment program; to provide timely assessments and reviews within established guidelines; and to identify services gaps within their region in the continuum of care.

The State's administrative/management partner, an administrative services organization, has as its primary role to maintain and monitor the full complement of treatment and prevention services, including negotiating contracts; to meet service gaps identified through the RADACs and ADAS; to provide timely, accurate and appropriate payments; and to ensure federal block grant and other requirements are met by subcontractors through compliance monitoring.

CFS Privatization: SRS has entered into a contractual relationship with a private agency for the administration and delivery of child welfare services. In the five child welfare regions, a Kansas-based private, nonprofit provider provides all behavioral health services. All CFS contractors (subcontractors to the lead agency) provide assessments, overall case planning and coordination, and direct treatment services as well as administer the provided services, quality management, provider relations, information systems, and claims administration. SRS maintains the overall responsibility for the case plans and goals for children in SRS custody. SRS is responsible to the court system and to

the community for the services delivered to children in SRS custody and for monitoring the progress of the CFS contractors in meeting specific case plan goals and overall foster care program goals.

Financing of Plans

Alcohol and Drug Managed Care Model: Federal block grants and State appropriations fund the program. The RADACs are paid through an SRS/ADAS grant. The capitated rates, paid by the management organization, are based on historical data, populations that meet the guidelines, and a formula from the Center for Substance Abuse Treatment (CSAT). The management organization receives $500,000 for administration. Any savings are reinvested in program services.

CFS Privatization: Medicaid, Title IV-E, and State general dollars fund this program. SRS assumes full financial risk. Funding is combined into a case rate. The case rate was determined based upon historical data reflecting past costs for SRS services to children. Any generated savings are to be reinvested in services.

Coordination Between Primary and Behavioral Health Care

Alcohol and Drug Managed Care Model: Unless the consumer is referred directly from the hospital, there is no clear-cut coordination with ADAS and physical health care providers.

CFS Privatization: The CFS contractors assist in the coordination of services. Medicaid-eligible children must have early and periodic screening, diagnosis, and treatment (Kan Be Healthy) as part of the contractual agreement.

Consumer-Family Involvement

Alcohol and Drug Managed Care Model: Consumers were involved in the development of this program.

CFS Privatization: Prior to the issuance of the request for proposals (RFPs) for CFS contracts, input was solicited from community agencies, the court system, and foster parents.

Future Plans

Alcohol and Drug Managed Care Model: None.

CFS Privatization: None.

State Agency Administration

The SRS houses all three agencies: Medicaid, Mental Health, and Substance Abuse. Medicaid falls under the Adult and Medical Services Division, Mental Health under Mental Health and Developmental Disabilities Division, and Substance Abuse under ADAS.

Welfare Reform

- The Kansas Welfare Reform Plan emphasizes providing services for welfare clients who need help with substance abuse problems. The State has implemented a comprehensive screening, assessment, treatment, and outcome monitoring protocol. A preliminary screening, conducted by the welfare office, looks for signs of intoxication, dismissal from employment for substance abuse-related causes, addiction-related legal problems, acknowledgment by client of substance abuse problem, or a positive result on the CAGE screening instrument. If the screening is positive, the client is referred to a RADAC for an assessment and treatment placement. The five assessment centers monitor progress, approve continuing care, and discharge. The assessment center works with the substance abuse provider to determine when the client is in recovery and ready to resume employment activities. The assessment and treatment components are funded by substance abuse sources. If a client is Medicaid eligible and has committed a drug felony, he or she will be denied coverage.
- Kansas' Welfare to Work grant submitted to the U.S. Department of Labor on December 12, 1997, and approved on March 2, 1998, will be administered by the Department of Human Resources, within SRS. The sources of matching funds and percentage of local, State, and private in-kind will be determined by the 1998 Kansas legislative session. The 15 percent of State project funds will be used based on proposals from Private Industry Councils, governmental entities, community-based organizations, and community development corporations to fund diverse activities. The substate allocation for the remaining 85 percent will be split between Temporary Assistance for Needy Families (TANF) and the poor.

County

In Kansas, the primary local coordinating agency for community-based mental health services is the licensed community mental health center. There are 30 of these located across Kansas. Some of these are incorporated as part of the local county government and some are freestanding entities that receive part of their funding from local government. The State also provides a substantial amount of public funding for these centers. They are all licensed by the Division of Mental Health and Developmental Disabilities.

Evaluation Findings

Alcohol and Drug Managed Care Model: SRS/ADAS funds Kansas State University to conduct evaluations on clients 6 months after discharge from treatment. ADAS also is implementing a CSAT Treatment Outcome study that includes an evaluation of the managed care model.

CFS Privatization: James Bell Associates external review services will provide a systematic review of all elements of the child welfare system; state management, quality control, and oversight; state service delivery; and private agency delivery of family preservation, foster care/reintegration, and adoption services. The review contract began in February 1998.

Additionally, SRS will monitor five general categories of outcomes, including the safety of children from maltreatment while in placement; number of placements after referral to KanCare for Families; the maintenance of family, community, and cultural ties; the amount of time for family reunification; and client satisfaction.

Other Quantitative Data

Not applicable.

KENTUCKY

OVERVIEW

Kentucky is preparing to implement a managed care waiver specific to behavioral health services. The State received approval for two waivers: one for primary care and a stand-alone model for behavioral health. The 1115 physical health waiver includes mental health services delivered by primary care providers and inpatient medical detoxification. The behavioral health waiver is a 1915(b) waiver, entitled Kentucky Access, which will be implemented in conjunction with the phase-in of the physical health program, Health Care Partnerships. Kentucky is the only State in the country to handle its entire Medicaid population through regional noncompetitive provider networks. If this approach does not prove effective, the State will move to a competitive bidding process.

Similar to the physical health care program, Access will be implemented on a region-by-region basis by partnerships of public and private behavioral health care providers.

Managed Care Programs for Behavioral Health Services

MEDICAID WAIVERS

Section 1915(b) - Access - behavioral health stand-alone: Risk-based carve-out managed behavioral health care program.

Section 1115 - Health Care Partnerships - general health - integrated: Primary health managed care program.

MEDICAID VOLUNTARY

Not applicable.

OTHER MANAGED CARE PROGRAMS

Not applicable.

Geographic Location

Section 1915(b) - Access: Will be implemented on a regional basis until statewide. Kentucky has been divided into eight managed care regions.

Section 1115 - Health Care Partnerships: Implemented on a regional basis until statewide. Kentucky has been divided into eight "Partnership" regions.

Status of Programs

Section 1915(b) - Access: Submitted December 1996. Approved March 7, 1997. Regions 3 and 5 Access target date is November 1998. Remaining Access plans managed behavioral health care organizations (MBHOs) will be implemented with Health Care Partnerships. Scheduled to be implemented on the same schedule as the Health Care Partnerships program.

Section 1115 - Health Care Partnerships: Approved October 1, 1995. Partnerships began serving clients in Region 3 on July 1, 1997, and in Region 5 on November 1, 1997. Remaining regions will be phased in beginning in the winter of 1998.

Medicaid Substance Abuse Services Remaining Fee-For-Service

Detoxification.

Medicaid Mental Health Services Remaining Fee-For-Service

Inpatient; outpatient (e.g., clinic services, community mental health centers (CMHCs)); Institution for Mental Diseases (IMD) services (for individuals age 65 and over and age 21 and under); mental health rehabilitation (CMHC and targeted case management).

Medicaid Substance Abuse Services in Managed Care Plan

Section 1915(b) - Access: For adults with serious mental illness, detoxification.

Section 1115 - Health Care Partnerships: Acute detoxification.

Medicaid Mental Health Services in Managed Care Plan

Section 1915(b) - Access: Inpatient; outpatient (e.g., psychiatry and licensed or certified practitioners); IMD services; mental health rehabilitation (CMHC and targeted case management); mental health residential (e.g., residential crisis stabilization); mental health support (e.g., community and family support, "IMPACT Plus" children's services, transportation); prescription drugs (e.g., pharmacy).

Section 1115 - Health Care Partnerships: Crisis (e.g., emergency room); mental health outpatient (e.g., primary care visits); prescription drugs (e.g., pharmacy).

Non-Medicaid Substance Abuse Services in Managed Care Plan

Not applicable.

Non-Medicaid Mental Health Services in Managed Care Plan

Not applicable.

Substance Abuse Prevention and Mental Health Promotion in Managed Care Plan

Section 1915(b): Preventive services.

Section 1115 - Health Care Partnerships: Early and periodic screening, diagnosis, and treatment (EPSDT) and wellness programs.

Populations Covered Under Managed Behavioral Health

Section 1915(b) - Access: Children and adults mandatory: Aid to Families with Dependent Children/ Temporary Assistance for Needy Families (AFDC/ TANF); Supplemental Security Income (SSI); Seventh Omnibus Budget Reconciliation Act (SOBRA); dually eligible; foster care; psychiatric child.

Section 1115 - Health Care Partnerships: Children and adults mandatory: AFDC/TANF, SSI, SOBRA, dually eligible, foster care, psychiatric child.

State Managed Care Program Administration

Section 1915(b) - Access: The Department for Medicaid Services will be responsible for overall implementation of Kentucky Access, and will contract with MBHOs organized by coalitions of behavioral health care providers. Medicaid will issue an invitation for traditional Medicaid behavioral health providers to register jointly as an MBHO. There are no requirements for nonprofit status. The MBHO will provide governance and provide and arrange for covered services on an at-risk, prepaid capitated basis. Coalitions must include a representative of a regional mental health/mental retardation board, an acute care hospital with inpatient psychiatric services, a community-based agency or a psychiatric residential treatment facility, a mental health professional, and the Department of Psychiatry Chairperson at the School of Medicine within the region. If a coalition forms and demonstrates ability to manage behavioral health care, Medicaid will contract with the MBHO that is organized by the coalition. If a single coalition cannot form or its application does not meet requirements, Medicaid will request competitive applications. Provider coalitions may still apply, but on a competitive basis with other organizations. No contract has been formalized. Organizers of coalitions have been recognized in Regions 3 and 5 and have been sent applications to become an MBHO.

Section 1115 - Health Care Partnerships: The Department for Medicaid Services has lead responsibility for this program, which contracts with provider organizations called Partnerships. A regional Partnership consists of representatives of all current Medicaid providers. The Partnerships enter into legal relationships with a Kentucky-licensed health maintenance organization (HMO), and together (as one entity or two) contract with Medicaid. Any willing provider may participate.

Financing of Plans

Section 1915 - Access: The program is funded by Medicaid. The MBHOs will be paid at a full-risk capitated rate. The capitation rate was established by actuaries using trended historical data. Providers are paid by the MBHO through subcontracts.

Section 1115 - Health Care Partnerships: Medicaid is the source of funds. Partnerships are at full risk and receive a capitated payment for each recipient's care. The capitation rate was established by actuaries using trended historical data. The State estimates it will save $31 million in its first year and roughly $117 million a year thereafter. Savings from the plan will be put into a trust fund earmarked for future expansion of Medicaid.

Coordination Between Primary and Behavioral Health Care

Section 1915(b) - Kentucky Access: Coordination of care is required by the MBHO and Health Care Partnership contract. In addition, the MBHO and Partnership in each region must have a local agreement that includes a coordinating function.

Section 1115 - Health Care Partnerships: Coordination of care is required by the MBHO and Health Care Partnership contract. In addition, the MBHO and Partnership in each region must have a local agreement that includes a coordinating function.

Consumer-Family Involvement

Section 1915(b) - Kentucky Access: Governing boards for regional plans must have five consumer, family, or parent members. Monitoring will be provided by units established in the Cabinet and advised by committees that include consumers and other stakeholders. The involved departments, consumers, family members, and other stakeholders have developed a set of quality outcomes and performance standards that the Cabinet will require of managed care organizations in Kentucky Access.

Section 1115 - Health Care Partnerships: Medicaid and each Partnership have advisory committees that include consumers and family members.

Future Plans

Section 1915(b) - Kentucky Access: Anticipated savings are planned to expand the array of services to divert beneficiaries from inpatient hospitalization. Such services include after-school programs for children and adolescents; partial hospitalization; residential care; crisis services; therapeutic foster care; and consumer support services.

Section 1115 - Health Care Partnerships: Savings will be used to expand Medicaid eligibility coverage to under- or uninsured citizens.

State Agency Administration

The Medicaid authority stands alone in the Department for Medicaid Services. The substance abuse authority is the Division of Substance Abuse, within the Department of Mental Health/Mental Retardation Services, which is the mental health authority. The Department of Mental Health/Mental Retardation Services and the Department of Medicaid Services are within the Cabinet for Health Services, which is accountable to the Governor.

Welfare Reform

TANF program went into effect on October 18, 1996. The program denies TANF benefits to drug felons but does not require drug testing of its recipients.

The State's Welfare-to-Work (WtW) plan became effective December 31, 1997, and is administered by the Cabinet for Families and Children. The goals of the program are to place and retain recipients in unsubsidized employment and to increase earnings to a predefined level. As a result of this program, demand for substance abuse services has increased. Medicaid and the Substance Abuse division are applying for a waiver to serve this population. One hundred percent of the matching funds are State dollars. The State project funds are intended to address substance abuse and domestic violence in the State. Fifty percent of the substate allocation is intended for poor individuals, and 50 percent for TANF recipients. There is a written agreement to define the roles of the local WtW entities and the local TANF agencies.

County

Not applicable.

Evaluation Findings

Studies of the impact of public sector managed care on access, quality, cost, or outcomes have begun but are not yet complete.

Other Quantitative Data

Section 1915(b) - Access: Access will use the Mental Health Statistics Improvement Program approach, including its consumer satisfaction survey and clinical outcomes developed for CMHCs and state facilities.

LOUISIANA

OVERVIEW

Louisiana is about to implement a 1915(b) waiver in Region 3, which will include some mental health services. Substance abuse is not covered by the program and remains in the fee-for-service system.

Managed Care Programs for Behavioral Health Services

MEDICAID WAIVERS

Section 1915(b) - Pilot - physical health - integrated: Health maintenance organization (HMO) program.

MEDICAID VOLUNTARY

Not applicable.

OTHER MANAGED CARE PROGRAMS

Not applicable.

Geographic Location

Section 1915(b) - Pilot: Region 3, which includes seven parishes (Assumption, Lafourche, St. Charles, St. James, St. John the Baptist, St. Mary, and Terrebonne).

Status of Programs

Section 1915(b) - Pilot: Submitted October 31, 1997; pending approval.

Medicaid Substance Abuse Services Remaining Fee-For-Service

Outpatient services (e.g., clinic services).

Medicaid Mental Health Services Remaining Fee-For-Service

Inpatient; outpatient (including clinic services); Institution for Mental Diseases services for individuals age 65 and over and age 21 and under; mental health rehabilitation.

Medicaid Substance Abuse Services in Managed Care Plan

Section 1915(b) - Pilot: Not applicable.

Medicaid Mental Health Services in Managed Care Plan

Section 1915(b) - Pilot: Outpatient, crisis, inpatient.

Non-Medicaid Substance Abuse Services in Managed Care Plan

Not applicable.

Non-Medicaid Mental Health Services in Managed Care Plan

Not applicable.

Substance Abuse Prevention and Mental Health Promotion in Managed Care Plan

Section 1915(b) - Pilot: Early intervention services.

Populations Covered Under Managed Behavioral Health

Section 1915(b) - Pilot: Children and adults mandatory: Aid to Families with Dependent Children/Temporary Assistance for Needy Families (AFDC/TANF); Seventh Omnibus Budget Reconciliation Act (SOBRA).

State Managed Care Program Administration

Section 1915(b) - Pilot: The Medicaid agency will contract with HMOs, which will provide all services. The HMOs must meet strict criteria and will be selected through a competitive process. The program has established a linkage with community mental health centers in Region 3 for children who meet certain criteria.

The health benefits manager (HBM) will serve as a buffer and facilitator between the HMOs and the Medicaid recipients. The HBM will establish education and outreach programs to provide easy-to-understand information to help the recipients choose from the plans offered by the HMOs, and the HBM will enroll the recipients into the HMO of their choice and with the primary care doctor of their choice. HMOs will not be allowed to market their programs directly to the recipients. The recipients will have 15 days in which to choose a plan and a doctor. If a recipient does not choose a plan or doctor, that recipient will be assigned to one for 6 months. During the first 30 days, recipients can change plans or doctors, if they desire. After 30 days, they are committed for 5 months to the plan they choose. After 6 months' enrollment, recipients may change plans or doctors.

Financing of Plans

Section 1915(b) - Pilot: Medicaid is the source of funds. HMOs will be at full risk for all services and paid a capitated rate.

Coordination Between Primary and Behavioral Health Care

Section 1915(b) - Pilot: The program requires that the primary care provider collaborates with behavioral health specialists.

Consumer-Family Involvement

Section 1915(b) - Pilot: Not applicable.

Future Plans

Section 1915(b) - Pilot: Integration is the goal of Louisiana's 1915 waiver. The State hopes to gradually go statewide with this program.

State Agency Administration

The Medicaid authority in Louisiana is the Bureau of Health Services Financing, which is housed within the Department of Health and Hospitals. The Department of Health and Hospitals also houses the substance abuse authority, the Office of Alcohol and Drug Abuse, and the mental health authority, the Office of Mental Health.

Welfare Reform

Louisiana's TANF program became effective January 1, 1997. It denies TANF benefits to drug felons. While the State does not currently test recipients for drug use, the Governor's Drug Task Force has released an implementation design that would include random drug testing for welfare recipients.

Louisiana's Welfare-to-Work plan was submitted to the Department of Labor on December 15, 1997, and was approved February 3, 1998. The performance goals of the program are to provide placement in unsubsidized jobs and increase duration of placements and earnings. The administering agency is the Department of Labor. Fifty percent of matching funds will come from the State; the other 50 percent will come from local and private sources. The intended use of State project funds are lighthouse projects with State-regional partnership agencies; incentive funds for Private Industry Councils exceeding performance goals and innovative demonstration projects; and statewide capacity building projects. Substate allocations will go equally to poor individuals and TANF recipients.

County

Not applicable.

Evaluation Findings

External parties, such as the Department of Insurance, the Federal government, and an external quality review organization, will assess and monitor the overall effectiveness of the project.

Other Quantitative Data

In Region 3 in 1995–96, the State spent about $56 million for health care services for about 28,000 AFDC and SOBRA recipients. The Federal government requires that the managed care pilot program be cost neutral. On the basis of the experiences of other States, the project should meet that requirement the first year, should realize savings of 5 percent in the second year and, if renewed, should generate substantial cost reductions and avoidances in the third and later years.

MAINE

OVERVIEW

Currently, behavioral health services are not included in Maine's voluntary Medicaid managed care program for 1915(b) Temporary Assistance for Needy Families (TANF) populations. However, the Medicaid Agency has adopted a rule to make the program mandatory and has included a basic mental health and substance abuse benefit. Adults with serious mental illness and children with severe emotional disturbance will continue to be excluded from the managed care program.

A separate Medicaid managed care program for elderly and disabled populations with acute care needs is being developed. A third initiative is being developed for long-term mental health and substance abuse services. The Department of Mental Health, Mental Retardation, and Substance Abuse Services (DMHMRSAS) is designing a program to combine Medicaid and non-Medicaid funding. It will cover all individuals not covered by the two acute care programs.

Managed Care Programs for Behavioral Health Services

MEDICAID WAIVERS

Section 1915(b) - Medicaid Managed Care Initiative (MMCI) - integrated with no behavioral health at present time.

MEDICAID VOLUNTARY

Not applicable.

OTHER MANAGED CARE PROGRAMS

Not applicable.

Geographic Location

Not applicable.

Status of Programs

Not applicable.

Medicaid Substance Abuse Services Remaining Fee-For-Service

Inpatient; outpatient (e.g., client services); detoxification; opiate treatment program (e.g., methadone treatment).

Medicaid Mental Health Services Remaining Fee-For-Service

Inpatient (e.g., clinic services and counseling); Institution for Mental Diseases (IMD) services for individuals age 65 and over and age 21 and under; mental health rehabilitation (e.g., targeted case management).

Medicaid Substance Abuse Services in Managed Care Plan

Not applicable.

Medicaid Mental Health Services in Managed Care Plan

Not applicable.

Non-Medicaid Substance Abuse Services in Managed Care Plan

Not applicable.

Non-Medicaid Mental Health Services in Managed Care Plan

Not applicable.

Substance Abuse Prevention and Mental Health Promotion in Managed Care Plan

Not applicable.

Populations Covered Under Managed Behavioral Health

Not applicable.

State Managed Care Program Administration

Not applicable.

Financing of Plans

Not applicable.

Coordination Between Primary and Behavioral Health Care

Section 1915(b) - MMCI: Coordination between primary and behavioral health care is through the client's primary care physician.

Consumer-Family Involvement

Section 1915(b) - MMCI: Not applicable.

- DMHMRSAS has convened a managed care steering committee composed of consumers, representatives from providers, advocacy organizations, and relevant State agencies to advise the Department as it plans for behavioral health managed care.

Future Plans

Section 1915(b) - MMCI: Basic behavioral health services will be phased into the program when it becomes mandatory. Medicaid has included a 20/30 for adults and 0/20 for children (inpatient/outpatient days or visits) behavioral health benefit that will be in place at least until a separate program is developed by DMHMRSAS.

★ *New Program Under Development:* The Department of Human Services has submitted an 1115 waiver to establish a long-term care demonstration program for elderly and disabled populations. Plans call for behavioral health services for elderly enrollees with acute needs to be included.

★ *New Program Under Development:* DMHMRSAS is developing a separate managed care initiative for long-term care services. Plans call for combining Medicaid and State funding for mental health and substance abuse services.

State Agency Administration

The State's Medicaid authority is the Bureau of Medical Services, within the Department of Human Services. DMHMRSAS is the State's mental health and substance abuse authority.

Welfare Reform

Maine's TANF program became effective November 1, 1996, and was certified complete on December 27, 1996. The program denies TANF benefits to drug felons, but does not require drug testing of its recipients.

County

Not applicable.

Evaluation Findings

Section 1915(b) - TANF program: Health Employer Data Information Set (HEDIS) compliance is not required; similar data are collected. No studies have been conducted.

Other Quantitative Data

Not applicable.

MARYLAND

OVERVIEW

Maryland's Section 1115 provides a seamless system of care of mental health, substance abuse, and physical health services to Medicaid recipients. Substance abuse services (as well as six other categories of special needs care) are provided by managed care organizations (MCOs) as part of HealthChoice physical health plan. Mental health services are provided by both MCOs and the specialty mental health system (SMHS). MCOs are responsible for providing "primary mental health services," which are the clinical evaluation and assessment of services needed by an individual and the provision of services, or referral for additional services as deemed medically necessary and appropriate by the primary care provider. The SMHS is administered by the Mental Hygiene Administration (MHA), in conjunction with local Core Service Agencies (CSAs) and a behavioral health company that assists them with administration and monitoring of the SMHS. On July 1, 1997, Medicaid funding for specialty mental health was combined with the resources of MHA to provide a single stream of funding to CSAs for mental health services for Medicaid recipients and the uninsured. The MHA contracts with a behavioral health managed care firm for administrative and monitoring services.

Before the waiver, Maryland Medicaid had approximately 120,000 voluntarily enrolled Medicaid eligibles in health maintenance organizations (HMOs). For these individuals, HMOs were responsible for physical health, mental health, and substance abuse services, except Institution for Mental Diseases (IMD) services for persons under age 21 and over age 65. Upon implementation of the waiver, this system was converted from a voluntary to mandatory system.

Managed Care Programs for Behavioral Health Services

MEDICAID WAIVERS

Section 1115 - HealthChoice - general health - partial carve-out for mental health.

MEDICAID VOLUNTARY

Not applicable.

OTHER MANAGED CARE PROGRAMS

Not applicable.

Geographic Location

Section 1115 - HealthChoice: Statewide.

Status of Programs

Section 1115 - HealthChoice: Submitted to the Health Care Finance Administration (HCFA) May 3, 1996; approved October 30, 1996; implementation of the changes to the public mental health system began on June 2, 1997; service provision under the managed care system began July 1, 1997.

Medicaid Substance Abuse Services Remaining Fee-For-Service

All Medicaid services provided to non-HealthChoice recipients are provided on a fee-for-service (FFS) basis. For individuals age 21 years and over, who are dually eligible or institutionalized, FFS-type services include substance abuse treatment services (e.g., outpatient treatment; narcotic treatment with methadone and LAAM; intensive outpatient treatment; emergency residential hospital detoxification).

For individuals under age 21 who are dually eligible or institutionalized, Medicaid FFS includes

substance abuse treatment services (e.g., outpatient treatment; intensive outpatient treatment; narcotic treatment and methadone and LAAM for individuals age 18 to 21 only; intermediate care; group home; emergency residential hospital detoxification).

For Temporary Cash Assistance (TCA) recipients covered under Medicaid FFS through welfare reform, services include substance abuse treatment services (e.g., intermediate care, halfway house, therapeutic community, group home) to adult and minor parents. TCA recipients receive all of the approved substance abuse treatment benefits under the HealthChoice program through the capitation received by the participating MCO. The services to TCA listed under the FFS category are in addition to the MCO capitation.

Medicaid Mental Health Services Remaining Fee-For-Service

Inpatient; outpatient (e.g., partial hospitalization, psychiatric rehabilitative programs, mobile treatment, community mental health programs); IMD services for individuals under age 21 and age 65 and over; mental health rehabilitation (e.g., targeted case management); expanded early and periodic screening, diagnosis, and treatment (EPSDT) services.

Medicaid Substance Abuse Services in Managed Care Plan

Section 1115 - HealthChoice: Outpatient (e.g., case management, diagnostic screening for substance abuse such as CAGE or MAST, comprehensive substance abuse assessment and placement criteria, counseling, intensive outpatient for pregnant women); detoxification (outpatient, inpatient if medically necessary); residential substance abuse treatment programs (e.g., intermediate care facilities for individuals under age 21); opiate treatment programs (e.g., methadone maintenance). For persons with HIV/AIDS and pregnant substance-abusing women, MCOs must provide access to substance abuse services within 24 hours of request. MCO providers also refer TCA adult and minor parents under welfare reform to the following services: intermediate care facilities for addictions, halfway houses, group homes, therapeutic communities.

Medicaid Mental Health Services in Managed Care Plan

Section 1115 - HealthChoice: Mental health services are managed by MCOs and the SMHS which is administered by MHA and paid for on an FFS basis. (See Program Administration Section for more details.) Primary mental health services (the clinical evaluation of assessment of services needed by an individual and the provision of services, or referral for additional services as deemed necessary by the primary care provider) are provided by MCOs.

Non-Medicaid Substance Abuse Services in Managed Care Plan

Not applicable.

Non-Medicaid Mental Health Services in Managed Care Plan

Not applicable.

Substance Abuse Prevention and Mental Health Promotion in Managed Care Plan

Section 1115 - HealthChoice: As of October 1, 1998, MCOs will be required to use standardized assessment and placement instruments: the Problem Oriented Screening Instrument for Teenagers (POSIT), the Addiction Severity Index (ASI), and the American Society of Addictions Medicine Patient Placement Criteria (2nd edition ASAM PPC-2). Primary care providers must conduct a substance abuse screening for all enrollees as part of their mandatory health assessment. The MCO must provide preventive and intervention services to the children. For persons with HIV/AIDS and pregnant substance-abusing women, MCOs must provide access to substance abuse services within 24 hours of request. MCO providers also refer TCA adult and minor parents under welfare reform to the following services: intermediate care facilities for addictions, halfway houses, group homes, therapeutic communities.

Populations Covered Under Managed Behavioral Health

Section 1115 - HealthChoice: Children and adults mandatory: Aid to Families with Dependent Children/Temporary Assistance for Needy Families (AFDC/TANF), Supplemental Security Income,

Seventh Omnibus Budget Reconciliation Act, uninsured and underinsured.

State Managed Care Program Administration

Section 1115 - HealthChoice: Maryland's Department of Health and Mental Hygiene (DHMH) contracts with nine MCOs to provide a comprehensive range of services, including substance abuse prevention and physical health promotion. MCOs can be licensed HMOs or new non-HMO organizations meeting the definition of MCO developed by the Maryland Insurance Administration (MIA) and DHMH. The same high quality and access standards apply to all MCOs. MCOs must meet the same reporting and other MIA standards as HMOs. Financial solvency requirements can be modified for new MCOs.

A major feature of the HealthChoice Program is the historic provider protection, which was built into the program to ensure their participation. Under HealthChoice, historic providers are ensured participation in at least one MCO. To be considered, a historic provider must meet the criteria set forth in the regulations. A provider who meets the criteria and has been unable to join any MCO will be assigned to an MCO by the Department.

The SMHS provides specialty mental health services through a unique partnership of public and private agencies. The MHA administers this portion of the program together with 18 local core service agencies. CSAs are locally based government or private nonprofit entities that fund community-based mental health services on behalf of the State. Under the carve-out, CSAs continue their role as local governance entities and as gatekeepers for clients. As of July 1998, the MHA holds contracts with providers and, in conjunction with CSAs, oversees the provision of services under those contracts. This arrangement ensures access to mental health services for persons with a range of mental health needs, including persons with serious mental illness (SMI). HealthChoice enrollees can be referred to the administrative services organization (ASO) for entry to the SMHS by their primary care provider or they can self-refer.

A private, competitively procured behavioral health MCO has been hired as an ASO to provide extensive administrative and monitoring services. The ASO enrolls patients, coordinates benefits, preauthorizes services, and provides other administrative services. The ASO does not oversee or manage the CSA functions. The MHA is responsible for overseeing all publicly funded mental health services. Monitoring CSA performance is the responsibility of the MHA, which contracts with each CSA. Providers need to fill out a provider application and have a contract with MHA in order to participate in the provider network.

Financing of Plans

Section 1115 - HealthChoice: The Medicaid agency makes capitated payments to MCOs for Medicaid physical and other special needs care, including substance abuse. MCOs are paid by the State through actuarially sound, risk-adjusted capitation rates, and most services are provided through the MCO.

MCOs have stop loss insurance, by which an MCO enrollee whose inpatient hospital costs exceed $61,000 in the contract year shall be enrolled in the Stop Loss Case Management (SLM) Program for the remainder of the contract year. After enrollment in the SLM Program, the enrollee will remain in the MCO for all MCO-covered health care services. The State is liable for 90 percent of accrued inpatient hospital charges in excess of $61,000 and the MCO is responsible for the remaining 10 percent of charges. Patients will remain in the program for the duration of the contract year. The stop-loss case manager is responsible for developing a plan of care in consultation with the primary care provider at the MCO, the patient and the patient's family. If cost-effective, the SLM enrollees may receive an expanded set of benefits. The MCOs reassume full responsibility at the beginning of the following year.

SMHS: Under the specialty mental health system, the Medicaid agency transferred funds for community mental health services to MHA. MHA combines Medicaid with its resources (State mental health grant funds, State hospital funds) and allocates funds to CSAs. Each CSA is allocated a global budget based on historical rates of use. Specialty mental health services are not included in the MCO capitation rate. Localities are expected to remain within their budgets, and MHA does not pass risk

on to them. CSAs that overspend can receive additional funds from MHA if they can justify the need, although CSAs have an incentive to manage their funds efficiently because any unexpended funds in 1 year are rolled over and added to the next year's resources for that jurisdiction. The CSAs, in turn, pay providers on a FFS basis, with the ASO actually processing the claims and paying providers on behalf of the CSAs. The State decided upon using a regulated FFS system because this allowed MHA to abolish, for most services, the procurement process.

The ASO is paid a set fee for the provision of its services. It has no incentives to deny care.

Coordination Between Primary and Behavioral Health Care

Section 1115 - HealthChoice: This program operates as a seamless system of care whereby MCOs may provide some primary mental health and substance abuse services, but then refers to the public mental health system for other services.

Consumer-Family Involvement

Section 1115 - HealthChoice: Unknown for implementation stage.

Future Plans

Section 1115 - HealthChoice: On the basis of recommendations from the Long-Term Managed Care Advisory Committee, the State is developing projects in four areas: 1) encouragement of individual long-term care planning; 2) enhancement of home and community-based services; 3) client directed care; and 4) integrated care system projects.

State Agency Administration

The State's Medicaid authority is DHMH. The mental health authority, the MHA, and the substance abuse authority, the Alcohol and Drug Abuse Administration, are housed separately under the DHMH.

Welfare Reform

Maryland's TANF program became effective December 9, 1996. The program denies TANF benefits to drug felons. Local Departments of Social Services (LDSS) do not test TANF applicants or recipients for drugs, but do administer a screen similar to MAST or CAGE at application and redetermination to TANF recipients who are adults or minor parents. If this screen indicates potential substance abuse, or if the applicant or recipient acknowledges substance abuse, the LDSS notifies the appropriate MCO. Regardless of the results of the screen at the LDSS, the MCO must screen the TANF recipient for substance abuse because MCOs are required to screen all HealthChoice recipients for substance abuse.

Maryland has a Welfare-to-Work plan, which is administered by the Department of Social Services in each jurisdiction. Although mental health and substance abuse treatment services are delivered by the Medicaid program, the LDSS can consider a TANF recipient receiving substance abuse treatment as participating in a work-related activity. Furthermore, Medicaid received a modification of its 1115 waiver that allowed it to expand the following TCA services to TANF recipients who are adult (over age 21) parents: intermediate care facilities for addictions, therapeutic communities, and halfway houses. Medicaid is currently submitting another modification request that would extend substance abuse group home services to TCA parents under age 17, and therapeutic communities and halfway house services to parents age 18–20.

County

A Baltimore-based demonstration project was implemented prior to the waiver to provide single-stream-funded, partial capitated mental health services to no more than 300 Medicaid patients with SMI.

Evaluation Findings

Section 1115 - HealthChoice: The HealthChoice Program is monitored by the State based on specific quality, access, data, and performance standards for special needs populations: external quality medical record audits, information collected from MCOs (encounter data; Health Employer Data Information Set (HEDIS) utilization; and outcome reports), external focused studies using medical records, provider and recipient hotlines, and the ombudsman program. At a later date, MCO report cards will be developed and

disseminated in coordination with the Health Care Access and Cost Commission. In October 1997, Maryland released the nation's first State-sponsored HMO report card. The information in the report card comes from HEDIS data collected by the HMOs and from a consumer satisfaction survey.

Other Quantitative Data

Currently, 73 percent of SMHS patients are Medicaid recipients and 27 percent are non-Medicaid. Less than 10 percent of costs are attributed to the non-Medicaid population.

MASSACHUSETTS

OVERVIEW

With the implementation of a Section 1115 waiver in July 1997, Massachusetts entered a new phase of managed health care by expanding Medicaid eligibility and by continuing an integrated managed health care program under a new State benefit plan for Medicaid and non-Medicaid populations. The new waiver incorporates previous managed behavioral health care approaches established under a Section 1915(b) waiver.

Under Massachusetts' integrated system, consumers have two options to receive physical health services: 1) they can join a health maintenance organization (HMO) from which they receive all health and mental health/substance abuse services, or 2) they can see one of the physicians participating in the Primary Care Clinician Program (PCCP) as their primary health care provider and receive their mental health/substance abuse through the Behavioral Health Program (BHP), a mental health and substance abuse carve-out program.

The carve-out is a capitated program with shared risk and is currently operated by a private behavioral health managed care organization (BHMCO). The BHMCO is responsible for administering and delivering all Medicaid carve-out services as well as acute inpatient/diversionary services and emergency services funded by the Department of Mental Health (DMH). DMH transferred funding for these services to the Division of Medical Assistance.

Managed Care Programs for Behavioral Health Services

MEDICAID WAIVERS

Section 1115 - MassHealth - integrated and carve-out: Two choices: integrated HMO and PCCP with carve-out.

MEDICAID VOLUNTARY

Not applicable.

OTHER MANAGED CARE PROGRAMS

Section 1115 - MassHealth - integrated and carve-out: Provides physical health, mental health, and substance abuse services to working disabled adults, disabled children, and long-term unemployed individuals.

Geographic Location

Section 1115 - MassHealth: Statewide.

Status of Programs

Section 1115 - MassHealth: Submitted April 1, 1997; approved June 30, 1997. Phase II managed care; approved by the Health Care Financing Administration; approved by the state legislature July 1997. Beginning July 1, 1997, subsumed previous Section 1915(b) MassHealth Managed Care program and also expanded Medicaid eligibility (see Populations Covered Section).

Medicaid Substance Abuse Services Remaining Fee-For-Service

Outpatient (e.g., counseling, acupuncture detoxification, and special substance abuse services for pregnant women); inpatient (e.g., hospital); residential substance abuse (e.g., 24-hour, freestanding community detoxification).

Medicaid Mental Health Services Remaining Fee-For-Service

Inpatient (e.g., hospital, treatment for individuals under age 21); outpatient (e.g., clinic services,

psychological testing); pharmacy (e.g., prescription drugs); psychiatric day treatment.

Medicaid Substance Abuse Services in Managed Care Plan

Section 1115 - MassHealth:

HMO: Outpatient (e.g., outpatient acupuncture detoxification, clinically intensive structured day/evening substance abuse services, outpatient addictions, counseling); inpatient (e.g., medical intervention for substance abuse, medical and social components of detoxification for pregnant women, acute detoxification, subacute); crisis (e.g., emergency services, short term crisis stabilization); residential substance abuse (e.g., acute and short term).

BHP carve-out (PCCP): Outpatient (e.g., outpatient acupuncture detoxification, clinically intensive structured day/evening substance abuse services, outpatient addictions, counseling); inpatient (e.g., medical intervention for substance abuse, medical and social components of detoxification for pregnant women, acute detoxification, subacute); crisis (e.g., emergency services, short-term crisis stabilization); residential substance abuse (e.g., acute and short term).

Medicaid Mental Health Services in Managed Care Plan

Section 1115 - MassHealth:

HMO: Inpatient (e.g., Institution for Mental Diseases (IMD) services for individuals age 22–64, acute treatment for individuals under age 21); crisis (e.g., emergency); outpatient (e.g., 12 outpatient visits automatically authorized, clinic services, nonphysician providers, psychological testing, structured outpatient programs); support (e.g., day and evening programs, targeted case management, intensive case management, family stabilization programs); pharmacy (e.g., drugs, management); residential (e.g., stabilization services, treatment for children and adolescents); rehabilitation (e.g., home care services, partial hospitalization).

Although HMOs have always covered mental health and substance abuse services, new contracts as of July 1 include strengthened requirements for mental health/substance abuse services that mirror those of the PCCP carve-out and an increased management of managed care organizations' behavioral health benefits.

BHP carve-out (PCCP): Inpatient (e.g., IMD services for individuals age 22–64, acute, treatment for individuals under age 21); crisis (e.g., emergency); outpatient (e.g., 12 outpatient visits automatically authorized, clinic services, nonphysician providers, psychological testing, structured outpatient programs); support (e.g., day and evening programs, targeted case management, intensive case management, family stabilization programs); pharmacy (e.g., drugs, management); residential (e.g., stabilization services, treatment for children and adolescents); rehabilitation (e.g., home care services, partial hospitalization).

Non-Medicaid Substance Abuse Services in Managed Care Plan

Section 1115 - MassHealth:

HMO: Not applicable.

BHP carve-out (PCCP): Not applicable.

Non-Medicaid Mental Health Services in Managed Care Plan

Section 1115 - MassHealth:

HMO: Not applicable.

BHP carve-out (PCCP): Acute/diversionary (for uninsured) and emergency services.

Substance Abuse Prevention and Mental Health Promotion in Managed Care Plan

Section 1115 - MassHealth: None.

Populations Covered Under Managed Behavioral Health

Section 1115 - MassHealth: Adults and children mandatory: Aid to Families with Dependent Children/Temporary Assistance for Needy Families (AFDC/TANF) (at or below 133 percent Federal poverty level (FPL)); Supplemental Security Income (SSI); pregnant women and children under 1 year up to 200 percent FPL; families and long-term unemployed at or below 133 percent FPL.

State Managed Care Program Administration

Section 1115 - MassHealth: MassHealth is administered by the Division of Medical Assistance (DMA).

HMO: Under the HMO option, DMA's goal is to make the plans more accountable and provide a more comprehensive package of services through capitated managed care. Behavioral health services are not carved out but instead remain part of the MCO's service package.

DMA contracts with two private, not-for-profit provider-sponsored MCOs (prepaid health plans) and four private, not-for-profit HMOs. Except for one, all of the HMOs with whom the Division has contracted have some form of behavioral health contract with various types of providers including outpatient clinics and hospitals.

The DMA has several responsibilities with respect to the administration of the contracts between the Division and the HMOs, including administration (e.g., contract monitoring, dispute resolution); performance evaluation (e.g., monitoring, evaluation, auditing); enrollment, assignment, and disenrollment processes; and marketing.

BHP carve-out (PCCP): In collaboration with DMH, DMA contracts with a private, for-profit BHMCO for the administration and service delivery of the BHP carve-out. Under the terms of the contract, DMA is responsible for managing the contract with the BHMCO. DMA ensures that the BHMCO is in compliance with terms and conditions of the contract, reviews reports and other data, and provides direction on policy and procedures.

The BHMCO is directly responsible for the management of the provider network, which includes the procurement of the network, network management, utilization review, quality management, community relations, and claims processing. The BHMCO holds the contracts with all service providers for mental health and substance abuse services.

DMH transferred funding for the emergency services system as well as acute and diversionary mental health services to DMA. For all Medicaid members including members who are also DMH continuing care enrollees, the BHMCO is responsible for acute inpatient, outpatient, diversionary, and emergency services. For DMH continuing care members who are not enrolled in Medicaid, the BHMCO provides acute inpatient/diversionary and emergency services. Eligibility for Medicaid is the responsibility of DMA, which uses financial criteria in its eligibility determination. Eligibility for DMH continuing care is DMH's responsibility, which uses clinical criteria in its eligibility determination. DMA and DMH have oversight responsibilities of the BHMCO, while the BHMCO is responsible for the management of the acute mental health and substance abuse services delivered by the network providers. DMH retains responsibility for continuing care services.

The BHMCO contracts on a fee-for-service basis with individual and group practices, inpatient facilities (e.g., hospitals, freestanding detoxification facilities), partial hospitalization programs, acute residential programs, and community mental health centers to deliver behavioral health services. Individual psychiatrists and psychologists may contract with the behavioral health vendor. Social workers, licensed mental health counselors, and licensed substance abuse counselors must be a part of a group practice, or on staff with a hospital, community (mental) health center, and acute residential program.

For substance abuse, most traditional substance abuse safety net providers, defined as those contracting with the Bureau of Substance Abuse Services to provide the services identified above, are used for Medicaid reimbursed services if they desire.

Financing of Plans

Section 1115 - MassHealth:

HMO: The HMO option under MassHealth is financed by Medicaid. HMOs receive capitation payments for physical health and all mental health and substance abuse services. Certain services are not included in the capitation payment and are reimbursed to providers.

Under new contracts effective July 1, 1998 HMOs will receive an enhanced capitation payment for an expanded service package including alternative and diversionary services for mental health and prescription drugs (see Future Plans Section). The capitation rates are determined by taking into account

1. The upper payment limit;
2. The current experience of DMA's behavioral health vendor; and
3. The bid submission of DMA's behavioral health vendor.

Payment for subcontractors is determined between the MCO and the subcontractor. There are no financial implications of the new HMO contracts for the BHP carve-out.

BHP carve-out (PCCP): This program is financed through Medicaid and DMH dollars. DMH transferred its State funds for acute psychiatric services to DMA. These funds are blended at the State level. DMH is able to transfer funds to DMA through an interservice agency agreement between DMA and DMH.

The BHMCO receives three separate capitation payments based on eligibility groups. Three risk categories are used to determine the prepaid, per capita monthly payments: the disabled group (SSI and SSI Medical Assistance only), the nondisabled groups (primarily AFDC, refugees, and Medical Assistance clients under age 21), and long-term unemployed.

It is a shared risk/gain arrangement between DMA and the BHMCO for over/underspending within a set of financial limits. There is a 45 (BHMCO)/55 (DMA) percent split between DMA and the BHMCO on savings or loss with $20 million on the BHMCO profit and $5 million on the BHMCO loss.

The providers are not at risk and are paid on a fee-for-service basis by the BHMCO. There were no incentives built into the capitation rates for the BHMCO; however, there is a separate incentive (bonus/penalty) structure tied to a series of "performance standards." Performance standards are initiatives that reflect the priorities of DMA and the BHMCO. All performance standards have measurable goals that the BHMCO is required to meet. Depending upon the nature of the performance standard, the BHMCO has the opportunity to earn a financial bonus or can incur a financial penalty.

Coordination Between Primary and Behavioral Health Care

Section 1115 - MassHealth: The BHMCO and the PCCP have established a communication protocol between the BHMCO's network providers and the PCCP providers. Also, one of the performance standards requires hospitals to notify primary care clinicians when MassHealth members who are disabled are receiving inpatient psychiatric treatment.

Consumer-Family Involvement

Section 1115 - MassHealth: Phase I of the managed care program had limited consumer involvement in the design of the program. Consumers participated in the selection process of the new BHMCO. Through the consumer and the family councils, consumers and family members are able to advocate for their needs and voice their input in program design and implementation. Currently, several community and family councils meet regularly with the carve-out and the Division and provide input on MCO policies, practices, and administration. The HMOs will be required to participate in consumer and family advisory councils sponsored by the BHMCO. In addition, the HMOs are required to design and implement a plan to coordinate and facilitate members' access to behavioral health programs related to peer and self-group services. The HMOs are also required to develop and maintain an up-to-date directory of peer and self-help groups by geographic locations.

Future Plans

Section 1115 MassHealth:

HMO: In an effort to improve the quality of its Medicaid managed care program and make HMO enrollment a more attractive option to its medical assistance population, Massachusetts is planning to enter into longer, more intensive partnerships with fewer health plans. Officials hope the changes will lead more medical assistance recipients in mandatory managed care to choose HMOs rather than the PCCP. More specifically, Medicaid is currently in negotiations with HMOs for 5-year contracts effective July 1, 1998. HMOs will have to dedicate a full-time equivalent (FTE) MassHealth Director and FTE quality and behavioral health managers. Behavioral services will not be carved out but instead be part of the MCOs' service package. The goal is to make plans more accountable and provide a more comprehensive package of services through capitated managed care.

BHP carve-out (PCCP): Currently, none; however, the current BHMCO contract has been extended through June 30, 2000.

State Agency Administration

Massachusetts' Executive Office of Health and Human Services houses the DMA (Medicaid), the DMH, and the Department of Public Health. The Bureau of Substance Abuse Services is under the Department of Public Health.

Welfare Reform

- Massachusetts's Welfare to Work (WtW) Grant was submitted to the U.S. Department of Labor (DOL) on January 5, 1998, and approved February 19, 1998. It will be administered by the DOL and Workforce Division. Matching funds will come 100 percent from the State in the form of cash. The expenditure of 15 percent of the State's monies is at the Governor's discretion and may be used for management information systems hardware and software or any other service as provided by the regulation. Coordination mechanisms between local WtW entities and local TANF agencies require formal linkages. The State steering committee is made up of representatives from Departments of Transitional Assistance, Education, the Executive Offices of Health and Human Services, Administration and Finance and Transportation, the Division of Employment and Training, Corporation for Business, Work, and Leaning (the Administrative Agency), and the Department of Labor and Work Force Development (the lead State agency). Activities at the local level are coordinated by the 15 Regional Employment Boards. The Departments of Transitional Assistance and Employment and Training have a member on each board.

  Outcome measures include employment, retention, and increased earnings. The numbers entering employment, final completions, and interim benchmarks are also requirements of the plan. To date, there have been no regulations on which to set the interim benchmarks. Although the Federal legislation allows for the inclusion of mental health and/or substance abuse treatments in the WtW plan, the decision to provide these services will be made at the local level by the individual Regional Employment Boards.

- In Massachusetts' welfare reform plan, drug testing is not mandatory and those TANF recipients who are convicted of drug felonies will be denied benefits. There are no provisions in the TANF WtW plan to provide services specifically for public sector behavioral health clients.

County

Not applicable.

Evaluation Findings

Section 1115 - MassHealth: Independent follow-up surveys conducted by researchers at Suffolk University for years 2–5 of the carve-out (under Phase I) indicate that more providers than expected were doing well financially under the managed care program for mental health and substance abuse. In fact, in year 5 of the carve-out, 40 percent of the providers reported they were doing financially better than the prior year. However, outpatient providers and community mental health centers had to make special accommodations and change their organizations to participate effectively in managed care. In year 4 of the program,

- 51 percent increased in size;
- 70 percent expanded their variety of services;
- 34 percent greatly added or strengthened their Total Quality Improvement/Total Quality Management program;
- 59 percent expanded, greatly improved, or made many changes to their management information system;
- 20 percent increased their collection of data on utilization, expenditures, and outcomes;
- 80 percent devoted more staff hours each week to paperwork, utilization review, and Total Quality Improvement, as compared with clinical care;
- 50 percent devoted more time to training and supervision; and
- Most moved very slowly toward capitation; on average, 80 percent of current contracts were fee-for-service and 20 percent were capitated or partially capitated.

Growth continued in year 5, though at a slower rate. For example, 22 percent said they increased their size in year 5 (compared with 51 percent in

year 4). Only 42 percent expanded their continuum (variety of services) in year 5 (compared with 70 percent in year 4). However, more providers strengthened Total Quality Improvement/Total Quality Management in year 5 (68 percent), compared with a year earlier.

Providers were essentially evenly split on overall financial strength, with one-third financially better off, one-third about the same, and one-third worse off by year 4 than they were before managed care initiative. In year 5, more community providers (40 percent) reported doing better and fewer (27 percent) reported doing worse. Providers that did worse reported the following:

- Increased costs associated with seeing more severely ill patients and providing more intensive treatment;
- Shorter lengths of stay, which led to increased case turnaround and higher costs associated with this pattern of care;
- Low reimbursement rates; and
- High administrative costs, poor cash flow, and unreimbursed care as result of the MCO's prior approval and billing processes.

Another evaluation published in 1994 by the Heller School at Brandeis University found that, while saving $47 million in Medicaid funds, BHP increased the Medicaid penetration rate from 21.3 to 22.3 percent. Recidivism rates and the use of inpatient hospitals for substance abuse treatment were reduced, even though the range of 24-hour services for both mental health and substance abuse was increased to include freestanding detoxification centers, residential treatment facilities, and diversionary beds. Acupuncture as a detoxification strategy, clinic treatment and methadone dosing, and counseling all were expanded for persons with addictive disorders. The program also received a generally positive evaluation from providers regarding the quality of managed care staff treatment-related decisions.

Other Quantitative Data

Not applicable.

MICHIGAN

OVERVIEW

Michigan's statewide managed care strategy encompasses five managed care plans, including three comprehensive health plans and two stand-alones for specialty mental health, substance abuse, and developmental disability services and supports. Under a 1915(b) waiver, the comprehensive health program for low-income citizens is now operating as a pilot in a five county areas with mandatory enrollment. Under this program, qualified health plans (QHPs) manage primary care services. All Medicaid mental health and substance abuse services are part of the stand-alone.

In addition to the waiver program, two voluntary managed care plans that include some mental health services are operating in counties not covered by the pilot. However, once the comprehensive health program has been phased in statewide, the voluntary health maintenance organization (HMO) and primary care case management (PCCM) programs will be phased out.

Managed Care Programs for Behavioral Health Services

MEDICAID WAIVERS

Section 1915(b) - Comprehensive Health Plan - integrated: Provides physical health as well as basic mental health services.

Section 1915(b) - Managed Specialty Services Program (MSSP) - behavioral health stand-alone: Provides mental health and substance abuse services.

Section 1915(a) - Michigan Interagency Family Preservation Initiative (MIFPI) - integrated: Voluntary, capitated program that provides Medicaid covered and other noncovered behavioral health services for severely impaired multisystem children and adolescents.

MEDICAID VOLUNTARY

Voluntary HMO - integrated: Physical health program that provides limited mental health services to Medicaid recipients.

OTHER MANAGED CARE PROGRAMS

Section 1915(b) - Managed Specialty Services Program (MSSP) - behavioral health stand-alone: Non-Medicaid populations are wrapped into the waiver. The funding streams remain separate but this is invisible to the client.

Geographic Location

Section 1915(b) - Comprehensive Health Plan: Statewide.

Section 1915(b) - MSSP: Statewide.

Section 1915(a) - MIFPI: Two demonstration sites (Livingston and Van Buren Counties); 50 children are enrolled.

Voluntary HMO: Operating in 14 counties (approximately 300,000 people are currently enrolled).

Status of Programs

Section 1915(b) - Comprehensive Health Plan: Submitted September 1996; approved May 1997; implemented October 1, 1997, in five counties; statewide implementation January 1, 1998.

Section 1915(b) - MSSP: Submitted waiver June 1997; approved June 26, 1998; implementation to begin October 1998 pending the Health Care Finance Administration (HCFA) approval.

Section 1915(a) - MIFPI: Implemented.

Voluntary HMO: Approved and implemented January 1983.

Medicaid Substance Abuse Services Remaining Fee-For-Service

Detoxification (acute); pharmacy; laboratory.

Medicaid Mental Health Services Remaining Fee-For-Service

Inpatient (incorporates inpatient psychiatric services for individuals under age 21); outpatient (e.g., partial hospitalization, physician services, clinic services); rehabilitation; support (e.g., targeted case management, personal care services).

Medicaid Substance Abuse Services in Managed Care Plan

Section 1915(b) - Comprehensive Health Plan: None.

Section 1915(b) - MSSP: Under the MSSP, the following substance abuse services will be covered:

- Assessment, diagnosis, patient placement, and referral;
- Outpatient treatment (including individual, family, and group therapy);
- Intensive outpatient treatment; and
- Federal drug administration approved pharmacological supports.

Under the MSSP, the following substance abuse services will be allowable (out of savings):

- Residential (subacute) detoxification; and
- Residential services in an Institution for Mental Diseases (IMD) or non-IMD.

Section 1915(a) - MIFPI: Outpatient (e.g., counseling, group, and/or family counseling, intensive services).

Voluntary HMO: Not applicable.

Medicaid Mental Health Services in Managed Care Plan

Section 1915(b) - Comprehensive Health Plan: Outpatient (e.g., limited to 20 visits).

Section 1915(b) - MSSP: Crisis (e.g., emergency services), inpatient, outpatient, residential, support, rehabilitation, transportation, pharmacy.

Section 1915(a) - MIFPI: Unknown.

Voluntary HMO: Outpatient (e.g., responsible for up to 20 outpatient mental health visits for recipients who need short-term ambulatory care).

Non-Medicaid Substance Abuse Services in Managed Care Plan

Section 1915(b) - MSSP: Substance abuse services include the following:

- Room and board;
- Residential (allowed for Medicaid recipients out of Medicaid funds and/or other public funds);
- Subacute detoxification (allowed for Medicaid recipients out of Medicaid funds and/or other public funds); and
- Services required of women's specialty programs under the Federal Substance Abuse Prevention and Treatment Block Grant, including case management, transportation, and child care.

Non-Medicaid Mental Health Services in Managed Care Plan

Section 1915(b) - MSSP: Crisis (e.g., emergency services), inpatient, outpatient, residential, support, rehabilitation, transportation, pharmacy.

Substance Abuse Prevention and Mental Health Promotion in Managed Care Plan

Section 1915(b) - Comprehensive Health Plan: None.

Section 1915(b) - MSSP: Information and education, direct service models, population-based primary prevention.

Section 1915(a) - MIFPI: Early and periodic screening, diagnosis, and treatment.

Voluntary HMO: None.

Populations Covered Under Managed Behavioral Health

Section 1915(b) - Comprehensive Health Plan: Adults and children mandatory: Aid to Families with Dependent Children/Temporary Assistance for Needy Families (AFDC/TANF), Supplemental Security Income (SSI), optional expansion pregnant women and children.

Section 1915(b): MSSP: Adults mandatory: AFDC/TANF, SSI, dually eligible (Medicare/Medicaid), uninsured, underinsured. For the uninsured and underinsured, a "means test" is used to determine eligibility. The test is a clinical test: Does the person meet one of the priority populations definitions of the State Mental Health Code (serious

mental illness or severe emotional disturbance) or do they meet Federal block grant priorities?

Section 1915(a) - MIFPI: Voluntary: children and adolescents.

Voluntary HMO: Adults and children voluntary: AFDC/TANF; SSI.

State Managed Care Program Administration

Section 1915(b) - Comprehensive Health Plan: Medicaid contracts directly with HMOs. QHPs are the State designation for managed care organizations (MCOs) that provide or arrange for the delivery of comprehensive health care to Medicaid recipients in exchange for a fixed prepaid sum or per-member per-month (PMPM) capitation rate without regard to the extent or kind of service; the QHPs happen to be all HMOs currently; however, this wording in the request for proposals was an attempt to broaden the market and include physicians/hospital organizations.

Medicaid contracts with the QHPs on a competitive bid basis. An enrollment broker, under contract to Medicaid, informs beneficiaries of the choice of QHPs in their area and signs them up for a health plan. Medicaid pays the plans, collects data, conducts quality assurance assessments, and conducts beneficiary hearings. The QHPs are responsible for provider network, provision of services, and third-party liability determination and payment. The nature of each panel is determined by the QHP; many are closed-panel arrangements. The QHPs are almost exclusively private, not-for-profit entities (one is composed of a federally qualified health center and another is a for-profit HMO). HMOs are responsible for a limited (20 visits) behavioral health benefit and they do subcontract for the management/provision of that service/benefit.

Section 1915(b) - MSSP: Programs will be administered by the Department of Community Health (DCH), Mental Health, and Substance Abuse Service Division. DCH will set up a system in which community mental health boards will administer Medicaid and state-funded indigent care programs. The Division will sole-source to 49 community mental health service programs (CMHSPs) that have contracts with DCH.

There are 49 CMHSPs that cover all 83 counties in the state. All CMHSPs are governmental entities and are sponsored by county government. CMHSPs are defined in the State mental health code as follows: "'community mental health services program' means a program operated under chapter 2 as a county community mental health agency, a community mental health authority, or a community mental health organization." The types of CMHSPs are

- County community mental health agency: An official county or multicounty agency created under Section 210 that operates as a CMHSP and that has not elected to become a community mental health authority Section 205 or a community mental health organization under Act No. 7 of the Public Acts of the Extra Session of 1967;
- Community mental health authority: A separate legal public governmental entity created under Section 205 to operate as a CMHSP; and
- Community mental health organization: A CMHSP that is organized under the Urban Cooperation Act of 1967, Act No. 7 of the Public Acts of the Extra Session of 1967, being sections 124.501 to 124.512 of the Michigan compiled laws.

These entities are governed by a 12-member board, initially selected by the County Commission. At least one-third of the membership of the board must be primary consumers and family members of consumers.

CMHSPs are managers of the program and responsible for selecting providers. Many CMHSPs contract all or part of their services. For mental health, CMHSPs contract with more than 30 human service organizations (nonprofit agencies) that banded together to form a behavioral health network that will provide treatment services to employer group plans, MCOs, and Medicaid clients. For substance abuse, CMHSPs are required to subcontract with regional substance abuse (SA) coordinating agencies for the management of SA benefits.

There are 15 regional SA coordinating agencies. Two are part of CMHSPs, seven are part of local public health departments, three are quasi-governmental agencies formed under the Urban Cooperation Act, and three are private not-for-profit freestanding entities.

The administrative responsibilities of the SA coordinating agencies under the MSSP will include ensuring access, service authorization and utilization management, provider network development, customer services, grievance procedures, care coordination, data collection and reporting, quality assurance and performance indicators, and fiscal management. Coordinating agencies do not provide treatment services (some do have waivers to perform assessment services).

Coordinating agencies subcontract for treatment services with providers licensed by the State's Department of Consumer and Industry Services. To receive Medicaid and other public funding administered by DCH, the providers also must be accredited by one of five national accrediting bodies. In Michigan, there are approximately 795 licensed substance abuse treatment programs. Of these, approximately 394 are currently enrolled as Medicaid providers. Of the latter group, 275 were funded at the beginning of fiscal year 1998 by coordinating agencies to serve the non-Medicaid indigent population. When the MSSP begins, coordinating agencies will be required to contract, for at least the first 6 months, with existing enrolled Medicaid substance abuse providers who can meet the coordinating agencies' contract terms. Additional providers may be added to a coordinating agency's Medicaid managed care panel.

Section 1915(a) - MIFPI: The contract in the two pilot sites is with CMHSPs who function as the fiduciary agents for the project. Other organizations (social services, juvenile court, schools) share actual governance and pool some of their funds with the CMHSP. The steering committee (interagency group) determines the provider network.

Voluntary HMO: Under a voluntary Medicaid HMO program, Michigan's Medicaid agency contracts with 12 private, not-for-profit HMOs. Similarly, as under the comprehensive health plan, an enrollment broker, under contract to Medicaid, informs beneficiaries of the choice of HMOs in their area and signs them up for a health plan. Medicaid pays the plans, collects data, conducts quality assurance assessments, and conducts beneficiary hearings. The HMOs are responsible for provider network, provisions of services, and third-party liability determination and payment. The nature of each panel is determined by the QHP; many are closed-panel arrangements. HMOs are responsible for a limited (20 visits) behavioral health benefit and they do subcontract for the management/provision of that service/benefit.

Financing of Plans

Section 1915(b) - Comprehensive Health Plan: This program is financed through Medicaid. QHPs are paid a fixed prepaid sum or PMPM capitation rate.

Capitation rates were competitively bid within a bid corridor established by the State. Savings were assumed and built into the rate. If profits are generated, they accrue to the QHP. There are general provisions on profits in the State HMO law.

QHPs are either at full risk (licensed plans) or shared risk (unlicensed plans). The State offers no stop-loss coverage; it is up to the individual health plans to obtain some form of reinsurance.

Section 1915(b) - MSSP: This program will consolidate public funding for mental health and substance abuse services (e.g., Medicaid, State general funds, substance abuse block grant dollars) at the local level. Three phases of development have been proposed for the carve-out. Phase I includes a carve-out to existing public entities and stresses functional consolidation of funding streams (e.g., same local entity will receive capitated Medicaid funds as well as indigent care dollars), affiliation of various layers of governmental administration, and measurement of performance and preservation of public systems of care.

Phase II calls for opening of the carve-out for bid and withdrawing the sole-source arrangement with pubic sector agencies. In phase III, the department will explore various models that integrate physical and behavioral health care management and service delivery. A key element in this approach is the prepayment, risk/award arrangement with the contractor, which encourages innovation, individualized care, and greater accountability.

The ultimate goal of the department is to promote coordinated community health care systems.

CMHSPs will receive several types of payments:

- During Phase I, the department will prepay CMHSPs on a capitated basis for mental health/substance abuse and developmental disability services. CMHSPs will subcontract with

regional SA coordinating agencies for management of Medicaid substance abuse services.

- Two separate capitation rates for mental health/substance abuse and developmental disability services under Medicaid. CMHSPs and DCH will share Medicaid costs for services over the established threshold and share cost savings. Capitation rates for mental health/substance abuse will be calculated using per capita methodology within a six-rate-cell structure. For developmental disabilities, capitation rates will be calculated using a per-eligible methodology within a four-rate structure. Those CMHSPs serving a larger population base and/or those CMHSPs with a more extensive and stable claims history for Medicaid covered services will be favorably rated in terms of percentage of premiums that must be set aside as dedicated contingency reserve fund.
- State general fund authorization for non-Medicaid eligible needing mental health services. CMHSPs will also receive a State general fund authorization to provide services to eligible service area recipients not covered by Medicaid.
- The Department will preserve a dedicated funding stream of State appropriations and Federal block grant allotments for substance abuse treatment and prevention services that will be distributed to existing regional Coordinating Agencies that are statutorily designated recipients of these funds.

The Department's proposed model would allow CMHSPs to share the savings of cost-effective care and permit them to reinvest these savings into the delivery system. Many CMHSPs do not have a sufficient population base to allow them to reap the full benefits of a managed care system. The Department strongly recommends in these cases a formal merger of CMHSPs as the preferred vehicle for consolidation. This, however, will be the county's prerogative. The Department will also permit smaller CMHSPs to participate in the prepaid plan if they come together into what the department is characterizing as Regional Management Networks to jointly administer the managed care plan.

Section 1915(a) - MIFPI: Programs under this initiative are capitated and at risk. Funds for the capitation amount vary depending upon recipient eligibility for various entitlement programs but are typically provided through Medicaid, Title IV funds, and local contributions. Funds are blended at the State level depending upon recipient eligibility. Capitation rates were determined by an assessment of historical costs for serving the target population and assessment of historic eligibility trends (for Medicaid, IV-E) for these recipients. It is a full-risk model; savings must be reinvested in program services.

Voluntary HMO: Medicaid dollars fund this program. HMOs are capitated and at risk. They may elect to subcapitate providers. Capitation rates are based on historical costs of the fee-for-service population minus a percentage reduction (1–10 percent depending on the region of the State). All savings are retained by HMO and there is no reinvestment requirement.

Coordination Between Primary and Behavioral Health Care

Section 1915(b) - Comprehensive Health Plan: QHPs and CMHSPs are required by contract to have written agreements stipulating referral processes, clinical coordination, information exchange, and dispute resolution processes.

Section 1915(b) - MSSP: CMHSPs will need to closely manage both their own (directly operated) services and those provided under contract (provider network) as an integrated and organized system of care. The care management responsibilities (access, services, quality) assumed by the Board, combined with the risk arrangements in the contract, will necessitate a new level of coordination and accountability between Board programs, and between the Board and its external suppliers.

Section 1915(a) - MIFPI: Both pilot sites have a multipurpose collaborative body, which is the local vehicle for coordinating services.

Voluntary HMO: Voluntary HMOs (just like QHPs) have limited mental health responsibilities (20 outpatient visits). They must have an agreement with CMHSPs for service coordination of other mental health services.

Consumer-Family Involvement

Section 1915(b) - Comprehensive Health Plan: Consumers and family groups were apprised of plan design but involvement was limited because of procurement issues. Stakeholder meetings and informational campaigns were used to solicit ongoing input from these groups. Consumers were required to comprise one-third of the membership of the QHP governing body. Furthermore, DCH has ongoing involvement with advocate groups. Consumers also participate in Readiness Review site visits and in communications to beneficiaries.

Section 1915(b) - MSSP: Phase III will introduce competitive procurement process, with consumers and family members participating in contractor selection.

Section 1915(a) - MIFPI: Consumers and families were on the planning team and are part of the multipurpose collaborative body that coordinates services at the local level.

Voluntary HMO: Consumers and families provided input in the design and implementation of this program through a Medicaid Advisory Council.

Future Plans

Section 1915(b) - Comprehensive Health Plan: Statewide expansion begins August 1998. Bids for regions of the State have been received and QHPs have been selected. Readiness reviews are being conducted.

Future plans under this program include contract changes to conform with the Federal Balanced Budget Act and implementation issues. The focus will be on reporting and performance outcomes.

Section 1915(b) - MSSP: There will be three phases of implementation (see Financing Section).

Section 1915(a) - MIFPI: Directors of State health, welfare, and human service departments, are examining the issue of how to encourage more pooled funding arrangements within local Child and Family Service Systems (the various health, welfare, education, juvenile justice, mental health, and substance abuse entities that provide services to children) by developing mechanisms for these agencies to share risks (rather than shift risk), distribute rewards (e.g., reduction in the use of highly restrictive service settings), and improve service outcomes.

Voluntary HMO: Physical health services of the voluntary HMO program will be subsumed by the comprehensive health plan (QHPs) program. Mental health and substance abuse services for all Medicaid recipients, regardless of health plan enrollment, will be subsumed by the MSSP.

State Agency Administration

The Department of Community Health oversees all three agencies: Medicaid, Mental Health/Substance Abuse and Developmental Disability Services, and the Public Health Agency. The Medical Services Administration, Mental Health/Substance Abuse Services Administration (which includes Developmental Disabilities), and the Public Health Agency serve as these agencies, respectively.

Welfare Reform

- Substance abuse treatment for public assistance clients: Substance abuse treatment services continue to be available for the public assistance clients. If the client is enrolled in Medicaid, services must be accessed through the Medicaid program. Otherwise, the client may be eligible for services funded by Substance Abuse Prevention and Treatment block grant funds and state general funds, which the Center for Substance Abuse Services administers. Family Independence Agency (FIA) clients with substance abuse problems are considered to have special needs and are required to be enrolled in either Michigan Opportunity and Skills Training (MOST) or WORK FIRST as part of their treatment plan. For those TANF eligibles convicted of a drug felony, benefits must be paid through a third-party payor contingent upon the individual meeting parole requirements.

  The State is monitoring the impact on SSI recipients under the Contract with America Advancement Act, which terminated SSI for those individuals deemed disabled due to any alcohol or drug addiction. The State contracted with Wayne State University to monitor the impact of the termination of substance abuse as a qualifying disability for SSI. Some data have been collected but no findings have been made and the Department has not issued any reports yet. The contract has been extended to September 30, 1998.

The regional assessment centers in Michigan are using the American Society of Addiction Medicine patient placement criteria, the Addiction Security Index for adults, and the Adolescent Drug Abuse Diagnosis instrument for adolescents for Medicaid clients seeking substance abuse treatment services.

- Michigan's Welfare to Work (WtW) Grant was submitted to the U.S. Department of Labor on December 11, 1997, and approved on January 29, 1998. Michigan Jobs Commission will serve as the administering agency of the grant. One hundred percent of State funds will serve as the matching fund source. The intended use of the 15 percent State project funds will be determined based on locally identified needs or distributed through formula. The substate allocation formula for 85 percent of the funds will be split 50/50 between the poor and TANF eligibles. Coordination between WtW entities and local TANF agencies will occur through the Jobs Commission, which reviews and approves local plans. Referral for substance abuse treatment is made to SA coordinating agencies and their assessment agencies for services. Outcome measures include placement and earnings in unsubsidized employment and increase in child support payments. The ultimate goal of Michigan's WtW grant is to develop a noncustodial parent program.

County

Not applicable.

Evaluation Findings

Section 1915(b) - Comprehensive Health Plan: Evaluations on access, quality, and cost are currently ongoing. Mandatory evaluations are being conducted by the legislature in addition to HCFA-required evaluations. Access is assessed via quarterly and annual reports; cost via monthly, quarterly, and annual reports. Quality improvement reports and encounter data systems are under way.

Section 1915(b) - MSSP: Mandatory evaluations are required under the waiver. A contractor has been selected and the design and evaluation process is being developed.

Other Quantitative Data

Not applicable.

MINNESOTA

OVERVIEW

The State currently has four physical health managed care programs that include behavioral health services and one that is specific to chemical dependency. Managed care programs in Minnesota are population based. Most programs focus on primary and acute care services, although one long-term care demonstration is now operating to serve dually eligible individuals. The predominant model for managed care in Minnesota has been the health maintenance organization (HMO) model, a concept pioneered in the State over 10 years ago.

It is the State's intention to eventually integrate the full range of services covered under all five programs into a comprehensive basic benefit package. However, new programs are also being developed to begin early in 1999 to include children with severe emotional disorders (SED) and adults with severe and persistent mental illness.

Managed Care Programs for Behavioral Health Services

MEDICAID WAIVERS

Section 1115 - Prepaid Medical Assistance Program (PMAP) - general health - integrated: Includes physical health, mental health, and chemical dependency for Medicaid recipients.

Section 1115 - Minnesota Senior Health Options (MSHO) - general health - integrated: Voluntary program for Medicaid and Medicare eligible individuals over age 65.

Section 1915(b) - Consolidated Chemical Dependency Treatment Fund (CCDTF) - substance abuse standalone: Specific to chemical dependency services. Covers substance abuse services on a fee-for-service (FFS) basis for Medicaid and general assistance recipients and others who meet income criteria.

MEDICAID VOLUNTARY

Not applicable.

OTHER MANAGED CARE PROGRAMS

Minnesota Care - Medicaid portion - integrated: Includes all Medicaid covered services for pregnant woman and children up to 275 percent of Federal poverty level (FPL). This program is for uninsured working poor and includes sliding scale premiums. General assistance non-Medicaid portion: includes acute care medical services and limited mental health and chemical dependency for childless adults up to 175 percent of FPL. This program is for uninsured working poor and includes sliding scale premiums.

General Assistance Medical Care Managed Care - general assistance program - integrated: Similar to PMAP, but applies to the 100 percent State-funded program for certain low-income adults who are not eligible for Medicaid and includes limited mental health and substance abuse services.

Geographic Location

Section 1115 - PMAP: Currently in the following counties: Anoka, Becker, Benton, Carlton, Carver, Chisago, Clay, Cook, Dakota, Faribault, Hennepin, Isanti, Itasca, Kandiyohi, Koochiching, Lake, Mahnomen, Martin, Norman, Ramsey, St. Louis, Scott, Sherburne, Stearns, Swift, Washington, and Wright. Plans to be statewide by 1999.

MSHO: Implemented in seven counties: Hennepin, Ramsey, Anoka, Dakota, Carver, Scott, and Washington.

Section 1915(b) - CCDTF: Statewide.

MinnesotaCare: Statewide.

General Assistance Medical Care Managed Care: Currently in the following counties: Anoka, Becker, Benton, Carlton, Carver, Chisago, Clay, Cook, Dakota, Faribault, Hennepin, Isanti, Itasca, Kandiyohi, Koochiching, Lake, Mahnomen, Martin, Norman, Ramsey, St. Louis, Scott, Sherburne, Stearns, Swift, Washington, and Wright. Plans to be statewide by 1999.

Status of Programs

Section 1115 - PMAP: Submitted July 1994; approved April 1995; implemented July 1995; expansion approved.

Section 1115 - MSHO: Implemented February 1997. Minnesota originally submitted a waiver with a concept similar to the current MSHO demonstration in 1991. This proposal was rejected in 1992, but the Health Care Finance Administration (HCFA) worked with Minnesota to support a planning grant from the Robert Wood Johnson Foundation that was granted in the fall of 1992. Subsequently, the State submitted a concept paper to HCFA but received no formal response. Therefore, the State began working on a waiver document and submitted it in draft to HCFA for preliminary review. MSHO submitted its formal proposal and its application for waivers to HCFA in April 1994. HCFA approved MSHO's waiver requests in April 1995.

Section 1915(b) - CCDTF: Approved January 1988, April 1996; implemented January 1988. A temporary renewal has been received for the waiver.

MinnesotaCare: Implemented September 1996.

General Assistance Medical Care Managed Care: Implemented July 1995; expansion approved.

Medicaid Substance Abuse Services Remaining Fee-For-Service

Opiate treatment programs; outpatient; inpatient; residential substance abuse treatment programs (e.g., extended care).

Medicaid Mental Health Services Remaining Fee-For-Service

Inpatient; outpatient (e.g., clinic services); mental health rehabilitation (e.g., day treatment, targeted case management); prescription drugs; mental health support for children (e.g., home-based services); Institution for Mental Diseases (IMD) services for individuals over age 65.

Medicaid Substance Abuse Services in Managed Care Plan

Section 1115 - PMAP: Opiate treatment programs; outpatient; inpatient.

Section 1115 - MSHO: All Medicaid services provided under PMAP: opiate treatment programs; outpatient; inpatient. Plus all Medicare services under Parts A and B. In addition, health plans provide services available under the current home and community-based waiver (Elderly Waiver), which consists mainly of extended home care benefits to frail elderly eligible for nursing home care.

Section 1915(b) - CCDTF: Outpatient (e.g., counseling); residential substance abuse treatment programs (non-hospital based 24-hour care); opiate treatment programs.

Medicaid Mental Health Services in Managed Care Plan

Section 1115 - PMAP: Inpatient; outpatient (e.g., clinic services); prescription drugs; mental health rehabilitation (e.g., day treatment); mental health support for children (e.g., home-based services). PMAP includes all mental health services covered by Medicaid except targeted case management and IMD services (unless the health plan chooses to cover those services as an alternative to a covered service).

Section 1115 - MSHO: Inpatient; outpatient (e.g., clinic services); mental health rehabilitation (e.g., day treatment); prescription drugs; IMD services for individuals over age 65.

Section 1915(b) - CCDTF: Outpatient; rehabilitation; mental health support; IMD services for individuals over age 65.

Non-Medicaid Substance Abuse Services in Managed Care Plan

MinnesotaCare: Opiate treatment programs; outpatient; inpatient; residential substance abuse treatment programs (e.g., extended care).

General Assistance Medical Care Managed Care: Opiate treatment programs; outpatient; inpatient.

Non-Medicaid Mental Health Services in Managed Care Plan

MinnesotaCare: Inpatient; outpatient (e.g., clinic services); mental health rehabilitation (e.g., targeted case management); prescription drugs; mental health support; IMD services for individuals over age 65.

General Assistance: Inpatient; outpatient (e.g., clinic services); mental health rehabilitation (e.g., day treatment, targeted case management); prescription drugs; mental health support.

Substance Abuse Prevention and Mental Health Promotion in Managed Care Plan

Section 1115 - PMAP: Early and periodic screening, diagnosis, and treatment (EPSDT) and additional services at the health plan's option.

Section 1115 - MSHO: EPSDT and additional services at the health plan's option.

Section 1915(b) - CCDTF: EPSDT and additional services at the health plan's option.

MinnesotaCare: EPSDT and additional services at the health plan's option.

General Assistance Medical Care Managed Care: EPSDT and additional services at the health plan's option.

Populations Covered Under Managed Behavioral Health

Section 1115 - PMAP: Children and adults mandatory: Aid to Families with Dependent Children/ Temporary Assistance for Needy Families (AFDC/ TANF).

Section 1115 - MSHO: Voluntary adults: dually eligible.

Section 1915(b) - CCDTF: Voluntary adults and children: uninsured, underinsured, AFDC/TANF, Supplemental Security Income, Seventh Omnibus Budget Reconciliation Act recipients not already covered under the PMAP or general assistance programs. The program's eligibility threshold includes, as an entitlement, everyone who would otherwise qualify under the State's eligibility criteria for Medicaid or general assistance, and depending on availability of funds, may also include uninsured and underinsured persons earning up to 115 percent of the State median income.

MinnesotaCare: Children and adults mandatory: general assistance, uninsured and underinsured, pregnant women and children. Medicaid eligibility is expanded for pregnant women and children up to age 20 with incomes up to 275 percent of FPL. The eligibility threshold for general assistance, uninsured, and underinsured is 175 percent of FPL.

General Assistance Medical Care Managed Care: Children and adults mandatory: general assistance. The program's eligibility threshold is persons earning 60–115 percent of the State median income.

State Managed Care Program Administration

Section 1115 - PMAP: The Health and Continuing Care Strategic Office (Medicaid) within the Minnesota Department of Human Services (DHS) contracts with prepaid health plans (PHPs), which are nonprofit HMOs and may provide the services directly or subcontract with other entities. The State contracts with eight health plans. Three of the eight plans subcontract for management of behavioral health services. Most of the payments from the three health plans to the subcontractors are in the form of capitation with shared risk; however, there are exceptions. As part of these contracts, PHPs are responsible for proper assessment and placement of clients.

Section 1115 - MSHO: Two divisions within the DHS have joint responsibility for MSHO: the Division of Purchasing and Service Delivery under the Health Care Administration, and the Aging Initiative. These agencies contract with for-profit HMOs, which are at full risk for both the healthy and frail elderly. HMOs may provide the services directly or subcontract services out to geriatric care networks. HMOs are encouraged to develop partnerships with long-term care providers and counties.

HCFA monitors and oversees the State's administration of MSHO and administers the Medicare payments to MSHO health plans. Under the waivers granted by HCFA to the State of Minnesota, the State provides most of the direct administration and coordination for the MSHO program. The State administers both Medicare and Medicaid administrative requirements for enrollees. It manages contracts for both Medicare and Medicaid with HMOs, Integrated Service

Networks (ISNs), and Community ISNs (CISNs) who have demonstrated the clinical capacity to integrate and manage primary, acute, and long-term care services. Administrative requirements for Medicare and Medicaid financial solvency, enrollment, marketing, quality assurance, data collection, grievance, and appeals are also streamlined and merged under the State's contracting authority.

In Minnesota, ISNs, CISNs, and HMOs must be not-for-profit organizations. However, the geriatric care networks or geriatric care providers do not have to maintain a not-for-profit status provided they are Medicaid and/or Medicare.

The characteristics of the geriatric care networks serving MSHO enrollees vary in structure and risk-sharing arrangements. They include the following: A partnership between an HMO, hospitals, clinics, and long-term care facilities; a hospital entity partnered with a broad-based long-term care provider; a group of long-term care providers who have created a joint venture for business arrangements with clinics and hospitals to manage a full spectrum of services on a capitated basis; and a group of nursing homes that have formed a cooperative for more efficient contracting and purchasing arrangements. In addition, a county-run HMO has entered into a unique agreement with the county's Public Health and Social Services offices to make available and manage home and community-based services as part of a move to integrate services. We are not aware that the networks use an any-willing-provider structure, as the whole point of the networks is to achieve closer coordination between acute and long-term care providers. However, MSHO health plan contracts do include a mechanism for payment of out-of-network nursing home providers so that placements may be made to facilitate consumer preferences that fall outside the networks.

Section 1915(b) - CCDTF: The Chemical Dependency Division of DHS allocates CCDTF funds to counties and Indian reservations, who manage and deliver chemical dependency treatment services. Counties contract directly with community providers through what is called a Host County Agreement. It is only after a signed contract is submitted to the DHS that providers are eligible to receive funding from the CCDTF. Therefore, the counties are responsible for selecting the providers and the array of services offered. Counties and Indian reservations act as case managers in determining the appropriate intensity of chemical dependency rehabilitative services needed by the enrollee, and restrict the enrollee to receiving those services from a specified provider. Counties are ultimately responsible for the final decision in client placement.

MinnesotaCare: The Health and Continuing Care Strategic Office, within the Minnesota DHS, contracts with PHPs, which are nonprofit HMOs and may provide the services directly or subcontract with other entities. The Contract Management Division, in cooperation with the Mental Health Program Division, manages the contracts with the health plans. As part of these contracts, PHPs are responsible for proper assessment and placement of clients.

General Assistance Medical Care Managed Care: The Health and Continuing Care Strategic Office, within the Minnesota DHS, contracts with PHPs, which are nonprofit HMOs and may provide the services directly or subcontract with other entities. Most of the payments from the health plans to the subcontractors are in the form of capitation with shared risk; however, there are exceptions. The PHPs are fully at risk unless they choose a lower capitation in return for an inpatient stop-loss. The Contract Management Division, in cooperation with the Mental Health Program Division, manages the contracts with the health plans. As part of these contracts, PHPs are responsible for proper assessment and placement of clients.

Financing of Plans

Section 1115 - PMAP: Medicaid is the source of funds for this program. PHPs are paid at a capitated rate. PHPs are fully at risk unless they choose a lower capitation in return for an inpatient stop-loss. Rates are based on trended historical fee-for-service (FFS) (with regular updates from FFS) and with a managed care savings factor of 10 percent for families with children plus 5 percent for the aged. Recipients are assigned rate cells based on several factors, including age, sex, Medicare, institutionalization status, eligibility status, and county of residence. Disproportionate share hospital payment adjustments and medical education are embedded in the FFS base from which each health plan's rates are

derived. A Managed Care Ratesetting Task Force has been established by the Minnesota legislature to provide input from the health plans, provider, counties, and advocates concerning alternative methodologies for setting capitation rates and alternative purchasing arrangements for managed care services. The Managed Care Ratesetting Task Force evaluated and developed recommendations concerning a competitive bid purchasing model and risk adjustment for future ratesetting years. The Task Force completed its work and reported to the 1997 Minnesota legislature. A related Risk Adjustment Task Force continues to work on developing rate setting mechanisms to include risk adjustment.

Section 1115 - MSHO: A private foundation grant and Federal matching Medicaid dollars are the sources for this program. HMOs are paid a capitated rate. Most of the payments from the health plans to the subcontractors are in the form of capitation with shared risk; however, there are exceptions.

MSHO based its rate setting methodology on appropriate Medicare Adjusted Average Per Capita Costs (AAPCCs), PMAP rates for Medicaid acute and ancillary services, average payments for home and community-based long-term care services and short-term nursing facility services. DHS provides each MSHO contractor with a monthly per capita payment per enrollee, which includes the PMAP capitation, a Medicaid Nursing Facility Add-on, and the Average Elderly Waiver payment as appropriate per MSHO's policies. HCFA makes direct payment to each MSHO contractor for the monthly AAPCC capitation. MSHO provides an increased Medicare capitation for frail elderly by applying an AAPCC risk adjustment factor. In exchange for these two Medicaid and Medicare capitation payments, MSHO contractors must provide all the medically necessary Medicaid, Medicare, Elderly Waiver, and Nursing Facility services for the individual enrollee, with the exception of long-term nursing home per diems.

Methods of payment for geriatric care networks vary. Each MSHO plan is expected to develop its own subcontracts with geriatric care networks to ensure enrollees have coordinated primary, acute, and long-term care services. DHS pays plans a capitated rate directly. In turn, a plan pays their networks pursuant to the terms of their subcontracts. A plan may not, however, require specific payments to be made directly or indirectly to a physician or physician group as an inducement to withhold, limit, or reduce services to a specific enrollee and must comply with the physician incentive requirements specified in 42 CFR 417.479.

In MSHO, Medicare and Medicaid funds are blended at the plan level. DHS provides each MSHO plan with a monthly per capita payment per enrollee, which includes the PMAP capitation, a Medicaid Nursing Facility Add-on, and the Average Elderly Waiver payment as appropriate per MSHO's policies. HCFA makes direct payment to each MSHO plan for the monthly AAPCC capitation. MSHO provides an increased Medicare capitation for frail elderly by applying an AAPCC risk adjustment factor.

Section 1915(b) - CCDTF: All funding sources (State general funds, Substance Abuse Prevention and Treatment (SAPT) block grant funds, Medicaid) for the Chemical Dependency Division are pooled by DHS and placed into the CCDTF. These funds are allocated to counties under a formula based on population, income, and welfare caseload, and to Indian reservations based only on population. The formula was developed through legislative action. Various savings estimates have been made, but overall expenditures go up as savings are used to serve more people. The county pays 15 percent of the treatment costs until its State allocation is expended. Thereafter, the county pays 100 percent of the costs until the maintenance of effort obligation is met. After these funds are expended, the county funds pay 15 percent and the CCDTF Reserved Fund pays 85 percent. Virtually all chemical dependency treatment services are provided on an FFS basis under the CCDTF.

Minnesota Care: State-only dollars is the source of funds for the non-Medicaid part of this program. PHPs are paid at a capitated rate. Federal funds are also used for the Medicaid portion. Recipient premiums are another source. The capitation rate was determined the same way as the rate for PMAP. Most of the payments from the health plans to the subcontractors are in the form of capitation with shared risk; however, there are exceptions. The PHPs are fully at risk unless they choose a lower capitation in return for an inpatient stop-loss; they may choose to receive a reduced rate if they elect a stop-gap coverage for inpatient.

General Assistance Medical Care Managed Care: State-only dollars is the source of funds for this program. PHPs are at full risk and are paid on a prepaid capitation basis. Rates and terms of payment are established the same way as PMAP.

Coordination Between Primary and Behavioral Health Care

Section 1115 - PMAP: Unknown.

Section 1115 - MSHO: Unknown.

Section 1915(b) - CCDTF: All providers must follow State rules regarding assessment procedures and determination of appropriate level of care.

Section 1115 - Minnesota Care: Unknown.

General Assistance Medical Care Managed Care: Unknown.

Consumer-Family Involvement

Section 1115 - PMAP: In 1995, the State conducted a million dollar study of consumer satisfaction with PMAP, prepaid General Assistance Medical Care (GAMC) and other health programs and found a very high level of satisfaction with the publicly funded managed care programs.

Section 1115 - MSHO: During the 5-year development phase of MSHO, several large public meetings and hundreds of smaller meetings were held to receive input on MSHO from the public. A formal advisory committee of 30 members met, and continues to meet quarterly, for updates and input into the program. Also, a departmental planning team and two external advisory panels met numerous times to develop organizational and clinical design documents which were then circulated to more than 100 individuals and organizations. In addition, MSHO staff have made numerous presentations to senior organizations and organizations of workers who advocate or provide social services to seniors. The formal independent evaluation of MSHO is just beginning via contract from HCFA to Dr. Robert Kane. Extensive enrollee consumer satisfaction surveys are in development. MSHO has also contracted with the National Chronic Care Consortium to conduct MSHO enrollee and family member focus groups.

Section 1915(b) - CCDTF: Substance abuse consumers were actively involved in the design of CCDTF. Consumers were involved in various task forces that led to the creation of CCDTF at the legislature in 1986.

Minnesota Care: Consumers and families can choose whether to enroll and pay the sliding scale premium. They can choose from eight health plans in most parts of the State.

General Assistance Medical Care Managed Care: In 1995, the State conducted a million dollar study of consumer satisfaction with GAMC and other health programs and found a very high level of satisfaction with the publicly funded managed care programs.

Future Plans

Section 1115 - PMAP: The Minnesota Demonstration Project for People with Disabilities program was submitted to HCFA as an amendment to the current PMAP program. This demonstration goes beyond the HMO model by allowing, at county option, inclusion of persons with long-term disabilities. County health plan partnerships will be capitated and at risk for the range of services covered. Current plans are for the program to begin early in 1999.

Section 1115 - MSHO: This program will continue to be expanded.

Section 1915(b) - CCDTF: This program will continue to be expanded.

MinnesotaCare: This program will continue to be expanded.

General Assistance Medical Care Managed Care: This program will continue to be expanded.

★ *New Program Under Development:* Children's Mental Health Collaboratives Capitation Option: This initiative is being developed for implementation by local children's mental health collaboratives, based on the Child and Adolescent Service System Program system of care model. It is expected to begin either late in 1998 or early in 1999. Targeted to children who have SED, this initiative is being developed to parallel the Medicaid initiatives. It will establish a collaborative as the managing entity for the delivery of services under a direct capitation or through subcapitation.

★ *New Program Under Development:* The State plans to expand managed care service delivery under Medicaid using integrated service networks; integrate Medicaid, MinnesotaCare, and GAMC and expand eligibility to additional uninsured low-income people; and link Medicaid and Medicare rate setting and data collection to Minnesota's

health care system reform efforts. Managed care entities may make special arrangements with existing local child mental health collaboratives (which typically involve county, mental health, public health, corrections, and schools). Implementation of the new program is scheduled in three phases: Eventually, the State plans to integrate the Medicaid Prepaid Health Assistance Plan, GAMC, and MinnesotaCare into one program with the same universal benefit set for enrollees and supplemental benefits (including long-term care and access services). Then, the State will phase out the CCDTF program and integrate all licensed treatment into the basic benefit package.

State Agency Administration

The Medicaid authority in Minnesota is the Health and Continuing Care Strategy Office, within the DHS. The mental health authority is the Mental Health Program Division, under the DHS. Substance abuse treatment is administered by the Chemical Dependency Program Division, also under the DHS.

Welfare Reform

Minnesota's Temporary Assistance for Needy Families (TANF) plan became effective in July 1997 and was certified complete the same month. Although the State does not deny TANF to drug felons, it does conduct random testings. An individual convicted of a drug-related offense after July 1, 1997, can be required to submit to a random drug test as a condition of eligibility.

The State submitted a Welfare-to-Work (WtW) plan to the U.S. Department of Labor on January 29, 1998. The grant was approved March 2, 1998. Any nonmedical treatment that is normally outpatient based could be approved and WtW funds could be used to pay for such services. This could include chemical dependency treatment or mental illness treatment providing the request is documented in the file as necessary for them to become employed. One basic caveat is that WtW funds cannot be used to supplant other funding sources for these programs. The administering State agency is the Department of Economic Security. Funds will be used to provide direct client services to WtW participants. The substate allocation will be split among TANF, poor, and unemployed.

- Minnesota received a waiver to operate "Work First" in Clay and Carver counties. For those applicants who are homeless, victims of domestic abuse, or in treatment for chemical dependency, a personal stabilization period of up to 8 weeks will be allowed before participation in an employment plan. Minnesota will provide Aid to Families with Dependent Children (AFDC) benefits (vendor payments for the family's rent and utilities) as the family's first 6 months of benefits. The State will provide up to 180 days of post-placement services after a person leaves AFDC for work. Transitional Medicaid Assistance and Transitional Child Care eligibility will be expanded. Participants will be sanctioned for failure to comply.
- In addition, under Title IV-A, Section 1115, of the Social Security Act, the AFDC barrier removal waiver was approved on August 16, 1996. This policy has been submitted as a State plan amendment that became effective in July 1997 and provides a basis for approval of Federal Medicaid funding for parents in the MinnesotaCare program.

County

The State and the Association of Counties reached an intergovernmental agreement, which allows county-based purchasing of managed health care. If counties perform this role, all funds will be passed to the county, but counties will need to ensure that any risk-bearing provider networks meet State insurance requirements.

Evaluation Findings

Not applicable.

Other Quantitative Data

Not applicable.

MISSISSIPPI

OVERVIEW

Mississippi does not include behavioral health services under managed care. However, in the last year, the Mississippi legislature took two actions that may have a significant impact on managed behavioral health care: passage of a mental health system reform bill and a committee vote to expand the State's primary care case management program, HealthMACS, implemented under a 1915(b) waiver.

Managed Care Programs for Behavioral Health Services

MEDICAID WAIVERS

Not applicable.

MEDICAID VOLUNTARY

Not applicable.

OTHER MANAGED CARE PROGRAMS

Not applicable.

Geographic Location

Not applicable.

Status of Programs

Not applicable.

Medicaid Substance Abuse Services Remaining Fee-For-Service

Outpatient; inpatient (e.g., hospitalization); residential substance abuse treatment for the early and periodic screening, diagnosis, and treatment population.

Medicaid Mental Health Services Remaining Fee-For-Service

Inpatient; outpatient (e.g., clinic services); prescription drugs; Institution for Mental Diseases (IMD) services for individuals under age 21.

Medicaid Substance Abuse Services in Managed Care Plan

Not applicable.

Medicaid Mental Health Services in Managed Care Plan

Not applicable.

Non-Medicaid Substance Abuse Services in Managed Care Plan

Not applicable.

Non-Medicaid Mental Health Services in Managed Care Plan

Not applicable.

Substance Abuse Prevention and Mental Health Promotion in Managed Care Plan

Not applicable.

Populations Covered Under Managed Behavioral Health

Not applicable.

State Managed Care Program Administration

Not applicable.

Financing of Plans

Not applicable.

Coordination Between Primary and Behavioral Health Care

Not applicable.

Consumer-Family Involvement

Not applicable.

Future Plans

None.

State Agency Administration

The Medicaid authority is the Division of Medicaid, within the Office of the Governor. The mental health authority is the Department of Mental Health. The substance abuse authority is the Division of Alcohol and Drug Abuse within the Department of Mental Health.

Welfare Reform

Mississippi's welfare reform program denies Temporary Assistance for Needy Families (TANF) benefits to drug felons, but does not test recipients for drug use.

County

On April 25, 1997, Mississippi signed into law SB 2100, a bill that served as a major step in efforts to reform an outdated mental health system and ensure consumers access to a continuum of services. The law gave the State mental health department control over 15 community health centers; established formal guidelines for mental health workers, a grievance procedure, and a case management system; and mandated regional crisis intervention system to care for patients who destabilize.

Evaluation Findings

Not applicable.

Other Quantitative Data

Not applicable.

MISSOURI

OVERVIEW

Missouri has two ongoing managed care activities that affect behavioral health services: A 1915(b) waiver for health services that includes some mental health services, and a managed fee-for-service (FFS) carve-out program for substance abuse treatment. Additionally, the State is involved in a system redesign effort that is assessing the possibilities of using managed care technologies to better manage the services provided to Department of Mental Health (DMH) clients.

Managed Care Programs for Behavioral Health Services

MEDICAID WAIVERS

Section 1915(b) - Managed Care+ (MC+) - physical health - integrated: Health maintenance organizations (HMOs) provide general health care services and typically subcontract with a behavioral health managed care company for mental health.

MEDICAID VOLUNTARY

Not applicable.

OTHER MANAGED CARE PROGRAMS

Comprehensive Substance Treatment and Rehabilitation (CSTAR) Program - substance abuse carve-out: CSTAR is managed separately from MC+, by the Division of Alcohol and Drug Abuse.

Geographic Location

Section 1915(b) - MC+: Implemented in four areas of the State: Eastern Region, Western Region, Northwest Region, and Central Region. A tentative implementation date of February 1, 1999, has been set for expansion of the 1915(b) managed care program to the Southwestern Region of the State.

CSTAR Program: Statewide.

Status of Programs

Section 1915(b) - MC+: Implemented in October 1995. The 1915(b) waiver was submitted April 24, 1995, to the Health Care Financing Administration (HCFA); it was approved September 29, 1995. The waiver expired September 1997. The State requested a 90-day extension for the current waiver September 17, 1997, which was approved by HCFA September 18, 1997. The extension period was in effect October 1, 1997, through December 29, 1997. On December 18, 1997, the State requested an additional 90-day extension, which was approved December 23, 1997.

The second extension period was effective December 10, 1997, through March 29, 1998. Missouri received approval for a 2-year continuation of the 1915(b) waiver March 12, 1998. Approval of the waiver request covers a period of 2 years from March 15, 1998, to March 14, 2000.

CSTAR Program: CSTAR as an FFS program was implemented January 1, 1991. Approved as carve-out from MC+ in July 1996. Phase-in implementation of managed care began November 1996. Implementation of managed care completed by July 1997.

Medicaid Substance Abuse Services Remaining Fee-For-Service

Inpatient; residential substance abuse services; outpatient.

Medicaid Mental Health Services Remaining Fee-For-Service

Inpatient; outpatient (e.g., clinic services); mental health rehabilitation (e.g., targeted case manage-

ment); prescription drugs; Institution for Mental Diseases services for individuals under age 21 or persons age 65 and older.

Medicaid Substance Abuse Services in Managed Care Plan

Section 1915(b) - MC+: All under CSTAR program.

Medicaid Mental Health Services in Managed Care Plan

Section 1915(b) - MC+: Mental health rehabilitation (e.g., targeted case management); inpatient; outpatient.

Non-Medicaid Substance Abuse Services in Managed Care Plan

CSTAR Program: The following CSTAR services are funded by Medicaid dollars: outpatient (e.g., day treatment, community support, individual, group and codependency counseling, group educational counseling, family therapy, extended day therapy). The following CSTAR services are covered by State matching funds: residential substance abuse treatment (e.g., non-hospital-based 24-hour care); outpatient; detoxification. CSTAR providers conduct assessments to determine the appropriate level of care.

Non-Medicaid Mental Health Services in Managed Care Plan

CSTAR Program: Not applicable.

Substance Abuse Prevention and Mental Health Promotion in Managed Care Plan

Section 1915(b) - MC+: Early and periodic screening, diagnosis, and treatment (EPSDT) screens.

CSTAR Program: Unknown.

Populations Covered Under Managed Behavioral Health

Section 1915(b) - MC+: Mandatory children and adults: Aid to Families with Dependent Children/ Temporary Assistance for Needy Families (AFDC/ TANF), Seventh Omnibus Budget Reconciliation Act (SOBRA) pregnant women and children.

CSTAR Program: CSTAR services are available to anyone who meets the DSM IV criteria for substance abuse and also meets the income guidelines for Medicaid. Most CSTAR clients have no insurance or very limited income. CSTAR targets Medicaid eligible women and children by offering programming unique to their needs, such as child care and residential support for women with children.

State Managed Care Program Administration

Section 1915(b) - MC+: The State Medicaid agency contracts with 14 for-profit and not-for-profit HMOs to provide services and program management. The Medicaid agency sets policy and provides program oversight and monitoring. A number of the HMOs subcontract mental health services to behavioral health managed care organizations. Health plans/behavioral health companies refer members seeking CSTAR services to a CSTAR provider. If a member refuses to receive care at a CSTAR provider, health plans are responsible for providing substance abuse services with an alternative plan provider qualified to provide substance abuse services. MC+ recipients are notified by the Division of Medical Services (DMS) that they can directly access CSTAR services without a referral from their primary care physician or health plan.

CSTAR Program: All adult substance abuse services are carved out of MC+ and managed separately by the Division of Alcohol and Drug Abuse (ADA), which is responsible for program administration activities and contracts with providers. The Division has an interagency agreement with the Medicaid agency for the portion funded with Medicaid funds. The ADA performs authorization for a service package, based on a detailed service matrix. If a physician thinks more services are necessary, a clinical review is performed by licensed clinical staff employed by ADA. CSTAR providers are responsible for determining level of care needed. The ADA developed a standardized assessment instrument based on the Addiction Severity Index and other instruments.

The provider network for CSTAR at present consists of agencies that have a contract with the Division of ADA to provide CSTAR services and that have been certified by the Division as a CSTAR agency. There are approximately 35 not-for-profit providers currently participating in the program; of these, 13 are women's and children's programs, 9 are

adolescent programs, and the rest are for the general population.

Financing of Plans

Section 1915(b) - MC+: Medicaid is the sole source of funding. HMOs receive a capitated payment. There is stop-loss for certain conditions. Missouri establishes an actuarially sound rate range. All competitive bids must be within this range to be accepted. Stop-loss provisions: Stop-loss limits apply only to hospital inpatient claims that exceed $50,000 per person, per health plan, per contract year. The State is responsible for 80 percent of the inpatient claims exceeding this threshold.

The base line cost and utilization data used to estimate the upper payment limits (UPLs) and establish the rate ranges during the MC+ contract periods were taken from the FFS information in the State's database. The FFS database is adjusted to reflect the portion of eligible services and expenditures for which participating plans will bear responsibility. Next, the adjusted database is used to calculate base per-member per-month rates, and these base rates are subjected to a series of adjustments to develop FFS-equivalent UPLs. Finally, the State's final rate ranges are calculated by adjusting the FFS equivalents for, among other things, changes in unit cost and utilization rates, which are expected to accompany managed care.

CSTAR Program: Medicaid, State-only funds, and Federal block grants finance this program. ADA combines general revenue funds and some portion of Federal block grant dollars for the Medicaid match. Providers are paid on an FFS basis. Providers' rates were established on a historical cost analysis of the fiscal year 1991 budget cost. The program is still under evaluation for cost savings. At present it is believed that any cost savings generated by utilization review will be reinvested in additional service availability.

Coordination Between Primary and Behavioral Health Care

Section 1915(b) - MC+: ADA and DMS consider referral and ongoing communication critical to ensuring coordination and continuity of care for MC+ members.

CSTAR Program: The Department of Mental Health (DMH) participates with the DMS Behavioral Health subgroup on quality improvement. This group has met with the CSTAR provider network and developed a notification of care activity report. This report is used to help link CSTAR participants to behavioral and physical health care.

Consumer-Family Involvement

Section 1915(b) - MC+: Prior to implementation of the 1915(b) waiver, DMS held public hearings across the State. In addition, the Missouri Health Watch—an advocacy group composed of persons from Legal Services of Eastern Missouri, the Missouri Association for Social Welfare, and other individuals concerned about the impact of managed care on Medicaid recipients—monitored the program development and made recommendations to DMS and to HCFA. Many of their recommendations were incorporated into the program.

The request for proposal called for the establishment of a consumer advisory group to assist in the development of educational materials and descriptions of grievance procedures. A separate Consumer Advisory Group has been formed to participate in the ongoing quality assessment and improvement process for the managed care program.

In the development of MC+, various committees looked at the different segments of health care delivery. The DMH was an active participant and conducted public forums. DMH's advisory councils, representing consumers, families, providers, and other agencies, were active in the planning and implementation of MC+.

CSTAR Program: Missouri statutes provide that ADA have a statewide advisory council to advise the Division on its programming efforts. This council is made up of consumers and providers. Additionally, the Division has six regional advisory councils, also consisting of consumers and providers, which act as subgroups of the statewide council. The statewide council and the regional councils play significant roles in the development of the Division's budget and future programming.

Future Plans

Section 1915(b) - Managed Care+: A tentative implementation date of February 1, 1999, has been set for expansion of the 1915(b) managed care program to the Southwestern Region of the State. There are no current plans to expand the 1915(b) managed care program to other regions in the State.

CSTAR Program: DMH is now involved in a significant system redesign effort known as the Psychiatric and Substance Abuse Treatment Services and Supports System Redesign Process. This effort is examining the possibilities of using managed care technologies to better manage the services provided to DMH clients. The effort will include significant public input and guidance from the Department's Mental Health Commission. An internal team of DMH staff has been established to study and plan the Department's approach to this effort. At present, CSTAR programming is considered to be a service that may be included in any new managed approach DMH may implement.

State Agency Administration

The Medicaid authority is DMS, which is within the Department of Social Services. The mental health authority is DMH, which also houses ADA, the substance abuse authority.

Welfare Reform

Missouri's TANF plan became effective in October 1996 and was certified complete in December 1996. The program denies benefits to drug felons but does not test its recipients for drug use.

Missouri's Welfare-to-Work plan was submitted to the U.S. Department of Labor on February 18, 1998. The administering State agency is the Division of Job Training and Development. Half of substate funds will go to poor individuals, and half will go to TANF recipients.

Rehabilitation Model for Child Welfare: Covers child protective services, residential care, family support, and aftercare services. The goal of this initiative is to restructure the child welfare service delivery system toward a managed, comprehensive continuum of care model consistent with programmatic objectives. Child Welfare, the DMH, and Medicaid contribute to the initiative. The State child welfare agency contracts with a managed care organization, which is at partial risk. This initiative will be implemented January 1, 1999.

County

Not applicable.

Evaluation Findings

Unknown.

Other Quantitative Data

Unknown.

MONTANA

OVERVIEW

The Montana Department of Public Health and Human Services operates three capitated programs, one specific to mental health and two for physical health services. Substance abuse services are excluded from the physical health managed care program and remain in the fee-for-service (FFS) system. The mental health waiver, known as the Mental Health Access Plan (MHAP), covers mental health services and integrates multiple funding streams (e.g., Medicaid, State hospital, general revenue, mental health block grant dollars) to serve Medicaid and non-Medicaid populations. A managed care organization (MCO) and a coalition of mental health and substance abuse providers, in a nonprofit joint venture, manage the plan.

Managed Care Programs for Behavioral Health Services

MEDICAID WAIVERS

Section 1915(b) - MHAP - mental health stand-alone: Provides acute and long-term care mental health services.

MEDICAID VOLUNTARY

Not applicable.

OTHER MANAGED CARE PROGRAMS

Not applicable.

Geographic Location

Section 1915(b) - MHAP: Statewide.

Status of Programs

Section 1915(b) - MHAP: Submitted May 7, 1996; approved August 1996; implemented April 1, 1997.

Medicaid Substance Abuse Services Remaining Fee-For-Service

Inpatient, detoxification, outpatient.

Medicaid Mental Health Services Remaining Fee-For-Service

Pharmacy.

Medicaid Substance Abuse Services in Managed Care Plan

Section 1915(b) - MHAP: Not applicable.

Medicaid Mental Health Services in Managed Care Plan

Section 1915(b) - MHAP: Inpatient (e.g., psychiatric hospitalization); Institution for Mental Diseases (IMD) services for individuals over age 65 and under age 21; outpatient (e.g., evaluation, assessment); crisis (e.g., emergency services 24 hours per day); residential; mental health rehabilitation (e.g., individual, group, and family therapy); mental health support.

Non-Medicaid Substance Abuse Services in Managed Care Plan

Section 1915(b) - MHAP: Not applicable.

Non-Medicaid Mental Health Services in Managed Care Plan

Section 1915(b) - MHAP: Mental health services include inpatient (e.g., psychiatric hospitalization); IMD services for individuals over age 65 and under

age 21; outpatient (e.g., evaluation, assessment); crisis (e.g., emergency services 24 hours per day); residential; mental health rehabilitation (e.g., individual, group, and family therapy); mental health support; pharmacy.

Substance Abuse Prevention and Mental Health Promotion in Managed Care Plan

Section 1915(b) - MHAP: Early and periodic screening, diagnosis, and treatment (EPSDT) for children. Mental health promotion strategies are being developed.

Populations Covered Under Managed Behavioral Health

Section 1915(b) - MHAP: Adult and children mandatory: Aid to Families with Dependent Children/ Temporary Assistance for Needy Families (AFDC/ TANF), Supplemental Security Income, Optional Expansion for pregnant women and children, State residents with an income up to 200 percent Federal poverty level (FPL), dually eligible Medicare/ Medicaid up to 200 percent FPL.

Non-Medicaid clients must qualify as having a severe and disabling mental illness (SDMI) for adults or a severe emotional disturbance (SED) for children according to State definitions in order to be covered under MHAP.

State Managed Care Program Administration

Section 1915(b) - MHAP: The Department of Public Health and Human Services' (DPHHS) Addictive and Mental Disorders Division (AMDD) contracts with Montana Community Partners (MCP) to provide mental health services under MHAP. The Addictive and Mental Disorders Division has responsibility for contract oversight including monitoring of access and quality of services.

MCP is a partnership between a private, for-profit MCO and a coalition (Care Coalition) of 30 human service organizations and community mental health centers (CMHCs). Care Coalition members have representation on the MCP Board of Directors. MCP has responsibility for service management, development, authorization, coordination, and provision; eligibility determination for non-Medicaid members; grievance and appeals handling; provider enrollment and payment; and quality assurance activities including outcome measurement. MCP is managed from a central program office in Billings, Montana, with satellite offices around the State.

Providers under the MHAP include any appropriately licensed or certified professional or facility, not just members of the Care Coalition. There is an open provider panel that must include at least all of the provider types that traditionally provide public mental health services. Specifically, the provider network consists of 671 individual providers as well as mental health professionals in community mental health centers, residential treatment centers, hospitals, and clinics. In communities where psychiatrists have not yet signed contracts with MCP, services are provided by primary care physicians (PCPs) and psychiatrists contracting with CMHCs or other MCP service providers.

Outstanding implementation issues include unpaid claims; provider resources necessary to track, resubmit, and otherwise resolve problems and disputed claims; continued inconsistency in the authorization of intensive services; time lags in authorization of outpatient services; and the length of time it has taken to negotiate and execute contracts with MCP. These issues were exacerbated by changes in the ownership of the behavioral health managed care organization (BHMCO). The BHMCO was bought by one private, for-profit BHMCO, which was then subsequently purchased by another private, for-profit BHMCO. While the latter two BHMCOs have more experience in the public sector than the original MCP partner, confusion and uncertainty caused by new corporate arrangements have prevented potential advantages from being fully realized.

MHAP's operational plan outlines many areas for improvement in the operations of MCP. The plan is the result of negotiations between the State and MCP to address the implementation problems experienced in Montana's MHAP. It includes provisions for compensation of the State, corrective actions to improve the operations of Montana's MHAP program, requirements to plan and implement longer term improvements, and amended reporting requirements. This plan serves as the basis for a contract amendment between MCP and the State to ensure acceptable levels of performance and accountability to the State of

Montana. Montana AMDD staff will establish teams to monitor MCP's compliance with the terms of the plan over the remaining life of the contract.

As an attempt to address these implementation issues, the State's contractor replaced the current management information services (MIS) system on July 1, 1998, in order to begin processing claims in a more timely and coordinated fashion.

Financing of Plans

Section 1915(b) - MHAP: Montana's DPHHS, AMDD entered into a statewide risk contract with MCP. This program comprises not only a capitated Medicaid carve-out for mental health services, but also all State-funded (including the mental health block grant) mental health services, specifically including the Montana State Hospital. The State pays the MCO a capitated rate for specified Medicaid services, along with a separate fixed sum for the Federal mental health block grant and State general revenue dollars for mental health. The amount paid for the block grant and State general revenue dollars reflects the amounts historically spent to provide services to the individuals meeting criteria for these funding streams. The money from all three funding sources is pooled at the MCO level. The MHAP contract is a full-risk contract with no stop-loss provision or risk corridors. Coalition providers are not at risk and are paid on an FFS basis but will participate in 50 percent of any "savings" achieved by MCP before the managed care company takes a profit.

The capitation rate paid to MCP is based on 5 percent less than historical costs. As for profits generated, the MCO is limited to either 0, 2.5, 5, or 7.5 percent profit, depending on the State's classification of their performance as inadequate, adequate, good, or superior. First-year performance is currently being assessed. MCP, however, has not experienced any profit for the first year; on the contrary, the plan has experienced very significant losses.

Coordination Between Primary and Behavioral Health Care

Section 1915(b) - MHAP: MCP provider is required, under the terms of the contract, to contact a member's primary care physician, when known.

Consumer-Family Involvement

Section 1915(b) - MHAP: MHAP was designed over 3 years with the assistance of a Mental Health Managed Care Advisory Group, which included primary consumers, family members of consumers, and representatives of advocacy groups. Various drafts of the MHAP request for proposals were widely distributed to anyone—especially consumer and family groups—who cared to receive it; comments and suggestions were solicited and frequently incorporated. Consumer comment was encouraged through meetings between Department staff and consumer groups, both face-to-face and using the State's interactive video system.

MCP's board of directors includes consumers and family members. MCP supports a statewide State Consumer Council that includes consumers along with other stakeholders. They are appointed by local Citizen's Advisory Councils that are open to all; meetings are widely publicized to consumers, family members, and other stakeholders.

In addition, in response to feedback from consumers and advocacy groups, MCP simplified its grievance and appeals process. The changes make the system more user-friendly and provide quicker resolutions. MHAP also utilizes MCP peer advocates, who help members or families resolve any problems with MCP care or services. They put their knowledge of MCP's system to use to the advantage of members and their families. They represent member and family interests within MCP.

Future Plans

Section 1915(b) - MHAP: DPHHS contracted for technical assistance with a management consulting firm with expertise in the managed care industry. The consulting firm facilitated the development of an "Operational Plan" (with specific deliverables, deadlines, and financial penalties) to help resolve lingering implementation problems of MHAP.

Additionally, DPHHS requested, through the executive planning process, increased funds totaling $12.7 million for the 2001 biennium for the mental health managed care program. Approximately $4.4 million is State general funds; the remainder is Federal Medicaid funds. The requests are for anticipated caseload increases, provider rate increases, and an anticipated revision (in the State's favor) of the Federal medical assistance percentage rate.

★ *New Program Under Development:* Children's Health Insurance Program will begin by September 1999.

State Agency Administration

DPHHS houses Medicaid, Mental Health, and Substance Abuse departments. The Medicaid Services Bureau is under the Health Policy and Services Division within DPHHS. Mental Health and Substance Abuse are in one division, AMDD.

Welfare Reform

Families Achieving Independence in Montana, Montana's welfare reform demonstration, approved in 1995, is expected to reduce the number of Montana's eligible for TANF and thus reduce the number of Medicaid-eligible individuals. Because the MHAP covers individuals with SMDI or SED when their family income is not greater than 200 percent Federal poverty level, the impact of losing Medicaid benefits will be lessened for those diagnosed with a mental illness. Montana specifically included a psychotropic medication benefit in the MHAP for non-Medicaid eligible members as a way to allow individuals with a serious mental illness to take employment without risking loss of subsidized medications that would normally occur when they lost eligibility for Medicaid. For those individuals with substance abuse problems, Montana does not require mandatory drug testing; however, if an individual qualifies for TANF and commits a drug felony, he or she will be denied TANF benefits.

County

Not applicable.

Evaluation Findings

Unknown.

Other Quantitative Data

Not applicable.

NEBRASKA

OVERVIEW

Nebraska has two Medicaid managed care waivers: one waiver is for mental health and substance abuse, and one is for physical health services. Although geographical implementation has varied by components, the two waivers operate as one managed care program. Contract programmatic requirements, as well as quality assurance requirements, are the same for both. Policies and procedures have been established to ensure a coordinated effort, and continuity of care is provided by the primary care physician and the mental health/substance abuse service provider.

The behavioral health stand-alone establishes an integrated service delivery system for mental health and substance abuse services for Medicaid and child welfare clients. This program is managed by a for-profit behavioral health managed care organization (BHMCO).

Additionally, the State has implemented a separate managed care program for clients receiving behavioral health services from State general revenue dollars. Under this program, the State has contracted with a private, for-profit BHMCO to perform utilization review for State-operated inpatient psychiatric facilities and community behavioral health services.

Managed Care Programs for Behavioral Health Services

MEDICAID WAIVERS

Section 1915(b) - Nebraska Health Connection Mental Health/Substance Abuse (MH/SA) - behavioral health stand-alone: Contract that covers behavioral health services on a capitated basis.

Section 1915(b) - Nebraska Health Connection Medical/Surgical Component - general health - integrated: The medical/surgical component consists of two capitated health maintenance organizations (HMOs) and a Primary Care Case Management (PCCM) Network in Douglas, Sarpy, and Lancaster Counties.

MEDICAID VOLUNTARY

Not applicable.

OTHER MANAGED CARE PROGRAMS

Behavioral Health Redesign - behavioral health stand-alone: The Nebraska Health and Human Services System, Department of Health and Human Services, has contracted with a private managed care organization under an administrative services only (ASO) arrangement to manage care for State-operated inpatient psychiatric facilities and community behavioral health services.

Geographic Location

Section 1915(b) - Nebraska Health Connection MH/SA: Statewide.

Section 1915(b) - Medical/Surgical Component: Douglas, Sarpy, and Lancaster Counties.

Behavioral Health Redesign: Statewide.

Status of Programs

Section 1915(b) - Nebraska Health Connection MH/SA: Submitted February 16, 1995; approved June 23, 1995; implemented July 1, 1995. Renewal application submitted November 17, 1997; renewal approved March 26, 1998.

Section 1915(b) - Medical/Surgical Component: Submitted February 16, 1995; approved June 23, 1995; implemented July 1, 1995. Extended until June 27, 1998.

Behavioral Health Redesign: Implemented January 1, 1997.

Medicaid Substance Abuse Services Remaining Fee-For-Service

Outpatient; crisis; inpatient; residential substance abuse treatment programs (e.g., non-hospital-based 24-hour care, day treatment). Substance abuse treatment at any level of care is not covered for clients age 21 and over.

Medicaid Mental Health Services Remaining Fee-For-Service

Inpatient; outpatient; mental health rehabilitation (e.g., services to assist individuals to develop or improve task and role-related skills and social and environmental supports); mental health residential (e.g., treatment foster care, treatment group home); crisis; Institution for Mental Diseases (IMD) services only for individuals age 20 and under or age 65 and older; prescription drugs.

Medicaid Substance Abuse Services in Managed Care Plan

Section 1915(b) - Nebraska Health Connection MH/SA: Not applicable for adults. For children, services include outpatient; crisis; inpatient; residential substance abuse treatment programs (e.g., non-hospital-based 24-hour care). Substance abuse treatment at any level of care is not covered for clients age 21 and over.

Section 1915(b) - Medical/Surgical Component: Outpatient services (e.g., counseling, therapeutic services); prescription drugs only for individuals under age 20. Medications must be prescribed; they may be legend, over-the-counter, or compounded medications.

Medicaid Mental Health Services in Managed Care Plan

Section 1915(b) - Nebraska Health Connection MH/SA: Inpatient; outpatient; mental health rehabilitation (e.g., services to assist individuals to develop or improve task and role-related skills and social and environmental supports); mental health residential; crisis; IMD services for all individuals.

Section 1915(b) Medical/Surgical Component: Outpatient; prescription drugs.

Non-Medicaid Substance Abuse Services in Managed Care Plan

Behavioral Health Redesign: Inpatient; outpatient (e.g., clinic services); residential substance abuse treatment programs (e.g., non-hospital-based 24-hour care settings); detoxification; opiate treatment (there is one methadone clinic in the State); and crisis services (which are designed primarily to address mental health issues, but a significant percentage of the population served is either dually disordered or substance abusing).

Non-Medicaid Mental Health Services in Managed Care Plan

Behavioral Health Redesign: Inpatient; outpatient; mental health residential (e.g., 24-hour residential care); mental health rehabilitation; mental health support; crisis; IMD services for all individuals.

Substance Abuse Prevention and Mental Health Promotion in Managed Care Plan

Section 1915(b) - Nebraska Health Connection MH/SA: Early and periodic screening, diagnosis, and treatment (EPSDT) screens.

Section 1915(b) Medical/Surgical Component: EPSDT screens.

Behavioral Health Redesign: None offered.

Populations Covered Under Managed Behavioral Health

Section 1915(b) - Nebraska Health Connection MH/SA: Children and adults mandatory: Aid to Families with Dependent Children/Temporary Assistance for Needy Families (AFDC/TANF), Supplemental Security Income (SSI), Seventh Omnibus Budget Reconciliation Act (SOBRA).

Income eligibility will be increased to 185 percent Federal poverty level (FPL) for pregnant women and children age 18 and younger, as of September 1, 1998. The children will be uninsured.

Section 1915(b) Medical/Surgical Component: Children and adults mandatory: AFDC/TANF, SSI, SOBRA. Income eligibility will be increased to 185 percent FPL for pregnant women and children age 18 and younger, as of September 1, 1998. The children will be uninsured.

Behavioral Health Redesign: Uninsured, underinsured. Currently, the Medicaid MH/SA program provides managed health care for mandatory Medicaid-eligible clients. The State is moving toward a behavioral health redesign to include management of behavioral health services to mandatory and nonmandatory Medicaid-eligible and non-Medicaid-eligible who are uninsured or underinsured.

State Managed Care Program Administration

Section 1915(b) - Nebraska Health Connection MH/SA: The Nebraska Health and Human Services System contracts with a for-profit BHMCO, which is at full financial risk. The managed care entity has an any-willing-provider arrangement and will enroll any provider that is enrolled with the Nebraska Medical Assistance Program and meets the managed care organization (MCO) standards. Some of the existing public behavioral health sector programs have become credentialed by the MCO to provide services.

Section 1915(b) Medical/Surgical Component: The Nebraska Health and Human Services System pays primary care providers (PCPs) a fee for gatekeeping services. All Medicaid-enrolled providers participate in the PCCM network. Physicians wanting to be PCPs sign an agreement with the PCCM network administrator.

Behavioral Health Redesign: The Department of Health and Human Services (DHHS) contracts with a private, for-profit MCO under an ASO arrangement to provide utilization management for all State-funded fee-for-service (FFS) programs. The ASO authorizes services and makes payments to providers, collects data, and monitors consumer outcomes. DHHS manages the provider network, as well as contracts with six Regional Centers, which provide inpatient and outpatient services.

In Nebraska there are six regions, composed of a varying number of counties, that define the geographic boundaries of the service areas within the State. The regions are defined in statute, and there are statutory provisions for these entities to make available behavioral health services within their geographic areas. The DHHS contracts with the six regions for the behavioral health services funded with State general, Federal MH/SA block grant, and other miscellaneous funds. Each region has a panel of providers that constitute a comprehensive array of behavioral health services. Most of these providers are private nonprofit entities that have subcontractual relationships with the regions in which they operate; however, Region I and Region II provide services directly under their own organizational auspices. Regional Centers are State-operated psychiatric hospitals that provide acute inpatient and secure residential levels of care. Each Regional Center serves a catchment area of designated regions. Hastings Regional Center serves Regions I, II, and III; Norfolk Regional Center serves Regions IV and VI; and Lincoln Regional Center serves Region V and provides the statewide forensic capacity. There is no contractual relationship between the Regional Centers and the State, as they are State-operated facilities.

Financing of Plans

Section 1915(b) - Nebraska Health Connection MH/SA: Medicaid is the source of funds. The MCO is paid on a capitated basis. Payment rates are based on paid claims data from previous years and financial information developed by an actuarial firm. The rates estimate a 76 percent upper payment limit savings for the State.

The BHMCO may obtain a risk-sharing arrangement from an insurer other than the Health and Human Services System for coverage of clients as long as it remains substantially at risk for the service provision under the contract. Providers are paid on an FFS basis, however. The contractor is doing some case rating with groups of providers, which includes a limited amount of risk.

The Medicaid Managed Care contractor is introducing the concept of risk into its Regional Care Continuum (RCC) development process. The RCCs are essentially provider networks under contract to provide Medicaid Managed Behavioral Health Service in the six service areas of the State. Each RCC has a budget developed based on paid claims experience with the contractor. Initially, there is no downside risk to the RCC, but it does have the opportunity to participate in a reward incentive pool based on its ability to outperform its budget. The contractor's goal in developing the incentivized budget plan is to provide RCCs with the opportunity to become comfortable with a risk

model without initially bearing any real risk. After a mutually agreeable period of time, the incentivized budget plan will convert to a risk/reward arrangement with the exposure of each party being negotiated based on the specific RCC and the unique risk-bearing capacities of each RCC partner.

Section 1915(b) Medical/Surgical Component: Medicaid is the source of funds. Providers are paid a set fee for gatekeeping services. The fee was set by administrative decision. No savings are anticipated from the PCCM.

Behavioral Health Redesign: State general revenue funds this program. The ASO is paid a set fee for administrative services. The Department pays Regional Centers according to a global budget for services. Providers are paid on a managed FFS basis. At the present time, there is no risk associated with the behavioral health redesign. Regional Centers, as State-operated facilities, are funded consistent with other State programs: An annual budget is established through the legislative appropriation process. The Department contracts with the six regions for non-Medicaid behavioral health services and pays them monthly for FFS costs (aggregated FFS claims from the subcontracted providers) and also for capacity-related costs (expense reimbursement) for those regional services that cannot easily be operated under an FFS arrangement. Providers are paid monthly by the regions, typically upon receipt of payment from the State.

Coordination Between Primary and Behavioral Health Care

Section 1915(b) - Nebraska Health Connection MH/SA: There is no formal link between physical health and mental health and substance abuse services.

Section 1915(b) Medical/Surgical Component: Primary care physicians refer patients to mental health and substance abuse services provided under the carve-out.

Behavioral Health Redesign: Primary care physician and MH/SA services provide coordination.

Consumer-Family Involvement

Section 1915(b) - Nebraska Health Connection MH/SA: Members of a stakeholder community helped with the planning of this program. Stakeholder members included representatives of the hospital, home, and insurance industries, six consumers, and community members. The State mental health authority and children's experts were also involved in the development of the waiver.

Section 1915(b) Medical/Surgical Component: Consumers and families provided input into the program through a public hearing, focus groups, and client/provider advisory groups.

Behavioral Health Redesign: Consumers and families provided input into the program through a public hearing, focus groups, and client/provider advisory groups.

Future Plans

The State plans to integrate all three of these programs in the future:

- *Section 1915(b) - Nebraska Health Connection MH/SA*
- *Section 1915(b) Medical/Surgical Component*
- *Behavioral Health Redesign:* The plan for this program is development of local integrated health networks that would create "ownership and partnership" of all health and human services at the local level.

State Agency Administration

The Department of Health is the Medicaid authority. The mental health and substance abuse authorities are under the Department of Public Institutions. Both Departments are housed within the Health and Human Services System, a super-agency that encompasses five major State departments.

Welfare Reform

The State's TANF program became effective December 1, 1996, and was certified complete December 7, 1996. The plan denies TANF benefits to drug felons but does not test recipients for drug use.

The State's Welfare-to-Work proposal was submitted to the Department of Labor on December 12, 1997, and was approved January 29, 1998. The administering State agency is the Department of Labor. Fifty percent of the matching funds will be State dollars. Fifty percent of the substate allocation will go to poor individuals; the rest will go to TANF recipients and the unemployed. The Welfare-to-Work program encompasses some mental health and substance abuse provisions.

County

Not available.

Evaluation Findings

The External Quality Audit and the FHC Options Quality Improvement Manager indicated the following Quality of Service and Quality of Care Studies/Pattern Analyses:

- Client Satisfaction Survey, 1996, 1997, 1998
- Provider Satisfaction Survey, 1996, 1997, 1998
- Readmission Study, 1996, 1997, 1998
- Access to care
- Migrations to higher and lower levels of care
- Outpatient follow-up after care
- Critical incidents
- Provider quality profiling
- Attention Deficit Hyperactivity Disorder (ADHD) medication management
- Reliability and validity of data entry into the data base
- Predictors of readmission

Most of these were verified through the External Quality Audit Review and were added since the last review report. All of these surveys, studies, and pattern of care analyses are indicators of the impact of managed care on the clients, providers, and system.

Other Quantitative Data

Enrollment is currently 110,000 statewide. The State is in the process of obtaining encounter data. Some utilization reports have been generated by the MCO for the State.

NEVADA

OVERVIEW

At this time, managed care systems do not include behavioral health services.

Managed Care Programs for Behavioral Health Services

MEDICAID WAIVERS

Not applicable.

MEDICAID VOLUNTARY

Not applicable.

OTHER MANAGED CARE PROGRAMS

Not applicable.

Geographic Location

Not applicable.

Status of Programs

Not applicable.

Medicaid Substance Abuse Services Remaining Fee-For-Service

Outpatient (e.g., clinic services) and ambulatory detoxification.

Medicaid Mental Health Services Remaining Fee-For-Service

Inpatient; outpatient; mental health rehabilitation (e.g., targeted case management); Institution for Mental Diseases (IMD) services for individuals age 65 and over and age 21 and under; mental health residential for children under age 21.

Medicaid Substance Abuse Services in Managed Care Plan

Not applicable.

Medicaid Mental Health Services in Managed Care Plan

Not applicable.

Non-Medicaid Substance Abuse Services in Managed Care Plan

Not applicable.

Non-Medicaid Mental Health Services in Managed Care Plan

Not applicable.

Substance Abuse Prevention and Mental Health Promotion in Managed Care Plan

Not applicable.

Populations Covered Under Managed Behavioral Health

Not applicable.

State Managed Care Program Administration

Not applicable.

Financing of Plans

Not applicable.

Coordination Between Primary and Behavioral Health Care

Not applicable.

Consumer-Family Involvement

Not applicable.

Future Plans

★ *New Program Under Development:* A subcommittee of the Nevada Center for Mental Health Services (CMHS) Block Grant Planning Council has been created to ensure State mental health and consumer participation in the likely evolution of behavioral managed care.

State Agency Administration

The Medicaid authority is the Medicaid Office, which is under the Division of Health Care Financing and Policy, Department of Human Resources. The mental health authority is the Division of Mental Health and Mental Retardation, housed in the Department of Human Services. The substance abuse authority is the Bureau of Alcohol and Drug Abuse (BADA), which is under the Department of Employment, Training, and Rehabilitation.

Welfare Reform

Nevada's Temporary Assistance for Needy Families (TANF) program went into effect September 30, 1996, and was certified complete December 24, 1996. The plan denies TANF benefits to drug felons. Effective January 1, 1998, TANF benefits are available to those individuals who 1) demonstrate they have not possessed, used, or distributed controlled substances since they began the program, or 2) are pregnant, and a physician has certified in writing the health and safety of mother and unborn child are dependent upon the receipt of cash benefits. The Welfare Division has contracted with BADA to provide substance abuse evaluation and treatment for all referred TANF recipients. Priority is given to pregnant women, teen parents, and individuals with more severe concerns. Case managers supply BADA with information on the eligible TANF client who is referred for assessment/treatment, such as gender, age, and information relating to medical condition, substance used, and frequency, among other things.

When a case manager has reason to believe a TANF participant's employability or parenting abilities may be affected by substance abuse, the case manager may refer the participant to a Division social worker. The social worker may administer a drug test. Eligibility for benefits is not affected solely by the outcome of the drug test. If the test produces a positive probability regarding substance dependence, the participant may be referred for further assessment. Further assessments are administered by a BADA-certified counselor or other qualified professional, who may refer for laboratory testing. If the participant refuses further assessment, treatment, or testing, the participant may be sanctioned for lack of cooperation. If tests are ordered by a qualified professional, the testing is paid for by the Division.

The State's Welfare-to-Work plan was submitted December 12, 1997, and approved January 29, 1998. Under this plan, $1 million has been allocated for substance abuse treatment services. The administering agency is the Welfare Division of the Department of Human Resources. One hundred percent of the matching funds are State dollars for fiscal year 1998. Substate allocation of funds is split between poor individuals and TANF recipients.

County

Not applicable.

Evaluation Findings

Not applicable.

Other Quantitative Data

Not applicable.

NEW HAMPSHIRE

OVERVIEW

New Hampshire has two publicly funded managed care programs. Neither required a the Health Care Financing Administration (HCFA) waiver. One is a voluntary health maintenance organization (HMO) managed care program covering physical health care and some mental health and substance abuse services for Aid to Families with Dependent Children (AFDC) eligible recipients. The Department of Health and Human Services (DHHS) has submitted a Section 1115 waiver to convert this program to a mandatory one, but this has not been approved yet. A second managed care plan is specifically designed for persons with serious mental illness (SMI). Under this plan, community mental health centers (CMHCs) are given financial incentives for high performance.

Managed Care Programs for Behavioral Health Services

MEDICAID WAIVERS

Not applicable.

MEDICAID VOLUNTARY

New Hampshire Managed Care - general health - integrated: Voluntary program that offers basic behavioral health services to AFDC/TANF (Temporary Assistance for Needy Families) recipients.

OTHER MANAGED CARE PROGRAMS

The New Hampshire Department of Mental Health and Developmental Services (NHDMHDS) - mental health stand-alone: The Department has made incremental steps toward managed care by allocating contract funds according to the provider's performance on consumer outcome measures.

Geographic Location

New Hampshire Managed Care: Statewide.
NHDMHDS: Statewide.

Status of Programs

New Hampshire Managed Care: Submitted: unknown; approved: unknown; implemented March 1983.
NHDMHDS: Implemented 1992.

Medicaid Substance Abuse Services Remaining Fee-For-Service

Acute detoxification (hospital-based only and based on medical necessity); outpatient.

Medicaid Mental Health Services Remaining Fee-For-Service

Inpatient; Institution for Mental Diseases services for individuals under age 22 and over age 65; outpatient (e.g., clinic services); mental health rehabilitation (e.g., targeted case management).

Medicaid Substance Abuse Services in Managed Care Plan

New Hampshire Managed Care: Inpatient; outpatient.

Medicaid Mental Health Services in Managed Care Plan

New Hampshire Managed Care: Inpatient; outpatient (e.g., therapy); crisis.

Non-Medicaid Substance Abuse Services in Managed Care Plan

NHDMHDS: Substance abuse services are funded under this formula for persons with a dual diagnosis.

Non-Medicaid Mental Health Services in Managed Care Plan

NHDMHDS: All community mental health services are funded under this formula.

Substance Abuse Prevention and Mental Health Promotion in Managed Care Plan

New Hampshire Managed Care: Early and periodic screening, diagnosis, and treatment (EPSDT) services; information dissemination on preventive health, systematic early identification and intervention for mental health and substance abuse services; mental health and substance abuse education and wellness (e.g., teen mother substance abuse prevention program, violence prevention programs, identification of symptoms of mental health and substance abuse).

NHDMHDS: Not applicable.

Populations Covered Under Managed Behavioral Health

New Hampshire Managed Care: Voluntary children and adults: categorically needy and foster care categorically needy.

NHDMHDS: Determined by level of need criteria (e.g., treatment and rehabilitation to children, older adults, and eligible adults; emergency services and eligibility assessment to anyone based on need).

State Managed Care Program Administration

New Hampshire Managed Care: The Medicaid agency contracts with one for-profit HMO. The HMO either provides behavioral health services itself or subcontracts them to CMHCs.

NHDMHDS: NHDMHDS is using administrative methodologies to manage the use of public funds for adults with SMI. NHDMHDS withholds 1 to 5 percent of CMHC allocations for a statewide pool for performance funding. Performance allocations are provided to CMHCs that demonstrate efficiency, effectiveness, and resource need. Approved CMHCs in each of the State's 10 regions provide the services.

Financing of Plans

New Hampshire Managed Care: Medicaid is the source of funding. The HMO is paid a capitated rate.

NHDMHDS: NHDMHDS is part of the State's mental health budget allocation. The Department reimburses providers based upon their performance on several key indicators including client employment, cost per client, and client tenure in the community.

Based on client assessments, all consumers served by the agency are classified into one of three eligibility categories: severe and persistent mental illness, serious mental illness (SMI), and formerly severe mental disability. The number of consumers within each of these three categories then forms the basis for allocation of State funds and use of State hospital beds.

At the beginning of the fiscal year, NHDMHDS computes the total State funds allocated for community-based services for persons with SMI in the previous fiscal year. This amount is then adjusted based on the availability of funds compared with the previous year. Once a total amount of available funds is determined, resources are factored out to fund existing and new statewide efforts, such as a statewide congregate living service for elders or statewide training initiatives.

Of the remaining funds, a selected percentage (usually between 95 percent and 99 percent) is used for base funding for the 10 local CMHCs; the other 1 percent to 5 percent of the available funds is used as a statewide pool to allocate to individual agencies based on performance on the designated statewide indicators. In addition, other new funds may be legislatively appropriated for development of specific initiatives, such as for children or elders. Ideally, NHDMHDS tries to reserve a minimum of 5 percent of the total available funds for "performance funding," although this is difficult in times of funding deficits. When available funding is limited, the Division tries to minimize the impact on the base funding by decreasing the size of the performance pool without totally eliminating it.

CMHCs receive performance funding if they demonstrate efficiency, effectiveness, or resource need. Efficiency is measured by relative cost of agency services per weighted client; effectiveness is measured by State hospital use and consumer

employment rates; and resource need is based on a comparison of effectiveness for agencies within the same efficiency range. Agencies with a low cost per weighted client either may be efficient or may be determined to be underfunded if hospital and employment outcomes are poor. If all agencies with relatively low funding per weighted client are achieving relatively poor client outcomes, it is an indication that more resources may be needed to strengthen the services. There also is an inherent assumption that continuous improvement is always possible.

Coordination Between Primary and Behavioral Health Care

New Hampshire Managed Care: When behavioral health services are subcontracted, long-term mental health services must be coordinated with the State-contracted CMHCs.

NHDMHDS: Not applicable.

Consumer-Family Involvement

New Hampshire Managed Care: Not applicable.

NHDMHDS: Consumers and families are represented on the State mental health planning council and on each of the 10 local planning councils.

Future Plans

New Hampshire Managed Care: Once the 1115 waiver is approved, this program will be terminated.

NHDMHDS: The Department's intent is to gradually reimburse providers on costs per client rather than on a unit cost basis. Currently, average costs are based on weighted eligibility category.

★ *New Program Under Development:* DHHS submitted a Section 1115 waiver to HCFA on June 5, 1996, that would include some acute mental health and substance abuse services. This program would convert the voluntary HMO program into a mandatory one. The Department will contract with HMOs, preferred provider organizations, commercial insurers, and nonprofit health service corporations, which will be at full risk. Plans will be selected through a competitive bidding process and paid a capitated rate. Plans will be required to contract with community health centers, if available, which will be paid on a fee-for-service basis.

State Agency Administration

The Medicaid authority is the Office of Medical Services, within DHHS. The mental health authority is the Division of Mental Health and Human Services, which also houses the substance abuse authority, the Bureau of Substance Abuse Services.

Welfare Reform

The State's TANF plan, filed with the U.S. DHHS on October 1, 1996, was determined to be complete on November 12, 1996. The plan does not deny TANF benefits to drug felons and does not test its recipients for drug use.

On June 18, 1996, the U.S. DHHS approved the waiver for New Hampshire's welfare reform demonstration project, the New Hampshire Employment Program. Substance abuse or mental health treatment is an approved "barrier resolution activity" for this program. The 5-year, statewide project includes mandatory job search and work requirements, a family cap, expanded transitional assistance, increased resource and asset limits, and changes to the earned-income disregard.

New Hampshire has submitted a Welfare-to-Work plan that includes additional activities and delivers a seamless system of services. Extra funds are being included in the New Hampshire Employment Program.

County

Not applicable.

Evaluation Findings

New Hampshire requires reporting and continuous quality improvement reports.

Other Quantitative Data

Not applicable.

NEW JERSEY

OVERVIEW

While the State Medicaid, mental health, and substance abuse agencies continue to plan for a behavioral health carve-out (see Future Plans Section), other managed care programs have been implemented that affect public sector mental health and substance abuse clients. The State is in the process of initiating a voluntary managed care program for disproportionate share hospitals (DSHs).

Managed Care Programs for Behavioral Health Services

MEDICAID WAIVERS

Section 1115 - Managed Charity Care Demonstration (MCCD) - integrated: Hospitals that voluntarily participate in the program provide limited mental health and substance abuse services to the non-Medicaid population.

MEDICAID VOLUNTARY

Not applicable.

OTHER MANAGED CARE PROGRAMS

Not applicable.

Geographic Location

Section 1115 - MCCD: Regional.

Status of Programs

Section 1115 - MCCD: Approved February 13, 1998.

Medicaid Substance Abuse Services Remaining Fee-For-Service

Inpatient (acute); outpatient (hospital-based only); opiate treatment.

Medicaid Mental Health Services Remaining Fee-For-Service

Inpatient; Institution for Mental Diseases (IMD) services for individuals under age 21 and over age 65; outpatient (e.g., clinic services, physician services, partial hospitalization); support (e.g., targeted case management, personal care, supervised housing, boarding homes).

Medicaid Substance Abuse Services in Managed Care Plan

Section 1115 - MCCD: Inpatient (acute); outpatient (hospital-based only); opiate treatment.

Medicaid Mental Health Services in Managed Care Plan

Section 1115 - MCCD: Inpatient; IMD services for individuals under age 21 and over age 65; outpatient (e.g., clinic services, physician services, partial hospitalization); support (e.g., targeted case management, personal care, supervised housing, boarding homes).

Non-Medicaid Substance Abuse Services in Managed Care Plan

Not applicable.

Non-Medicaid Mental Health Services in Managed Care Plan

Not applicable.

Substance Abuse Prevention and Mental Health Promotion in Managed Care Plan

Section 1115 - MCCD: None.

Populations Covered Under Managed Behavioral Health

Section 1115 - MCCD: Voluntary: uninsured (up to 300 percent Federal poverty level) with substance abuse problems or dually diagnosed with mental health and substance abuse problems.

State Managed Care Program Administration

Section 1115 - MCCD: The Department of Health and Senior Services (DHSS) administers the program. DHSS funds 60 hospitals. As a result of legislative changes in June 1998, hospitals now voluntarily participate. Other details are in development.

DHSS sets guidelines for how hospitals conduct the program and approves the hospitals' managed care plans and networks. Community substance abuse treatment providers at all levels of care participate in the network at the hospitals' initiation.

Financing of Plans

Section 1115 - MCCD: DSH funds serve as the major funding source for this demonstration. Some dedicated and some State general funds are blended with DSH funds. Hospitals are given a budget and placed at risk. There are no risk corridors. Charity care budget for each hospital is determined according to a State formula based on previous year charity care cost.

Coordination Between Primary and Behavioral Health Care

Section 1115 - MCCD: Details under development.

Consumer-Family Involvement

Section 1115 - MCCD: Every hospital is required to have a committee, but it is unknown if consumers and families will be included.

Future Plans

Section 1115 - MCCD: Implementation schedule to be announced. The waiver amendment is anticipated to convert the program to a voluntary demonstration.

★ *New Program Under Development:* The State released a request for proposals (RFP) for a Substance Abuse Initiative (SAI) on care coordination on April 1, 1998. The SAI grant will operate from August 1, 1998, until June 30, 1999. New Jersey is seeking to secure assessment, utilization management, care coordination, and case management services for Work First New Jersey (WFNJ) SAI and Substance Abuse Research Demonstration (SARD) project.

The SAI seeks to establish a coordinated, comprehensive continuum of substance abuse services, which will be available over the next several years to WFNJ recipients. WFNJ recipients are in the Temporary Assistance for Needy Families (TANF) and general assistance (GA) programs. Substance abuse treatment will be integrated along a continuum with work activities so that each can be substituted for the other as affected recipients move into recovery. The SAI will encompass screening and assessment in or near county and municipal welfare agencies, utilization management, care coordination, treatment, and aftercare. Through the RFP, the State will grant one entity which will supply, administer, and clinically supervise the work of 21 or more care coordinators and their assistants. The care coordination entity also will supply 10 case managers and 10 associate case managers to provide five two-person teams in Atlantic and Essex Counties for the SARD. The entity chosen is the National Council on Alcohol and Drug Dependence - New Jersey (NCADD-NJ) Chapter. The care coordinators will be employed by NCADD-NJ.

The services purchased through the RFP will coordinate the treatment provided by separate agencies into one continuum of care based on the American Society of Addiction Medicine Patient Placement Criteria Second Edition (ASAM PPC-2). This continuum of treatment services has been secured through a related RFP. The network will contain 99 agencies offering 358 programs covering all levels of ASAM PPC-2 services.

Reimbursement for services delivered through the care coordination grant will be made monthly or quarterly, depending upon the terms in the health service grant.

State Agency Administration

The New Jersey Department of Health houses the Division of Alcoholism, Drug Abuse and Addiction Services, and the Division of Medical Assistance and Health Services (Medicaid). The Department of Human Services houses the Division of Mental Health and Hospitals.

Welfare Reform

A two-site demonstration (SARD) for providing substance abuse services to WFNJ clients is in the first phase of implementation. Currently, New Jersey does not mandate drug testing of its TANF clients; however, it does deny TANF benefits to those eligibles convicted of drug-related felonies. A consulting firm has been selected to design the assessment process and treatment model; the project evaluation will be done by Rutgers University. The SARD began October 1998.

County

Not applicable.

Evaluation Findings

Section 1115 - MCCD: Hospitals must establish quality assurance programs that will monitor access and quality of care.

Other Quantitative Data

NJ KidCare: As of July 1998, 7,500 children are enrolled.

NEW MEXICO

OVERVIEW

New Mexico operates a 1915(b) integrated managed care waiver that covers all medical/surgical and specialty health care services, including mental health and substance abuse services for Aid to Families with Dependent Children (AFDC) and Supplemental Security Income (SSI) populations under a single capitated program called SALUD!, New Mexico Partnership for Wellness and Health. The program has a unique "carve-in" feature that requires health plans to identify and partner with organizations that specialize in managed behavioral health care.

Managed Care Programs for Behavioral Health Services

MEDICAID WAIVERS

Section 1915(b) - SALUD! - general health - integrated: Mental health services carved-in through New Mexico Partnership for Wellness and Health full-risk capitated program.

MEDICAID VOLUNTARY

Not applicable.

OTHER MANAGED CARE PROGRAMS

Not applicable.

Geographic Location

Section 1915(b) - SALUD!: Statewide

Status of Programs

Section 1915(b) - SALUD!: Waiver submitted December 5, 1996; approved May 13, 1997; implemented July 1, 1997. Statewide implementation complete June 1, 1998.

Medicaid Substance Abuse Services Remaining Fee-For-Service

Acute detoxification for adults. Additional inpatient and outpatient services for children and adolescents.

Medicaid Mental Health Services Remaining Fee-For-Service

Inpatient; outpatient (e.g., clinic services); rehabilitation (targeted case management). Other residential and community-based services for children.

Medicaid Substance Abuse Services in Managed Care Plan

Section 1915(b) - SALUD!: Outpatient. Managed care organizations (MCOs) are given the option to provide further substance abuse treatment for adults as enhancement.

Medicaid Mental Health Services in Managed Care Plan

Section 1915(b) - SALUD!: Inpatient; outpatient (e.g., clinic services); rehabilitation (targeted case management). MCOs are given the option of developing enhanced services that meet individuals' needs.

Non-Medicaid Substance Abuse Services in Managed Care Plan

Not applicable.

Non-Medicaid Mental Health Services in Managed Care Plan

Not applicable.

Substance Abuse Prevention and Mental Health Promotion in Managed Care Plan

Section 1915(b) - SALUD!: Substance abuse prevention services are not offered to adults through Medicaid managed care contracts. Individualized services can be offered as enhanced benefits. Drop-in centers operated by consumers are currently being developed.

Populations Covered Under Managed Behavioral Health

Section 1915(b) - SALUD!: Children and adults mandatory: AFDC, SSI, Medicaid expansion for pregnant women and children, Seventh Omnibus Budget Reconciliation Act (SOBRA). Native Americans have the option of choosing not to enroll with an MCO.

State Managed Care Program Administration

Section 1915(b) - SALUD!: New Mexico's Medicaid agency contracts directly with for-profit health maintenance organizations (HMOs), which are at full financial risk. HMOs are required to contract with behavioral health managed care organizations (BHCMOs) and to identify these partners in the bidding process. Contracts require delivery of a comprehensive, integrated benefit package of medical/surgical and specialty health services, including behavioral health at a fixed price per member per month. HMOs have partnered with three for-profit behavioral health organizations. BHMCOs contract with community mental health centers (CMHCs) and other local providers to provide services.

As the single State Medicaid agency, the Medical Assistance Division (MAD) is responsible for overall contract management. MAD contracts directly with the HMOs. The HMOs are responsible for ensuring that the BHMCOs perform their contractually required tasks. The BHMCOs contract with CMHCs and other local providers.

Financing of Plans

Section 1915(b) - SALUD!: The source of funds is Medicaid dollars. HMOs are paid a single capitation rate. HMOs are at full financial risk. Capitation rates are based on an actuarial analysis of old fee-for-service claims data. The BHMCOs are subcapitated. Payment to CMHCs is a combination of per diems and fee-for-service, which varies by center and BHMCO.

Coordination Between Primary and Behavioral Health Care

Section 1915(b) - SALUD!: The contract with MAD requires coordination; behavioral health providers are required to communicate with clients' primary care providers. Primary care providers are required to provide summaries of lab work, medications, physical medicine issues, among other things, to behavioral health providers.

Consumer-Family Involvement

Section 1915(b) - SALUD!: In collaboration with the Departments of Health, and Children, Youth, and Families, the Human Services Department held public forums statewide and met with advocacy groups to discuss the framework of the managed care model. A preprocurement conference was then held in September 1996 to discuss responses submitted by the public advocacy groups and potential managed care providers to draft a policy and quality standards document. At this conference, the State allowed those in attendance (more than 300 individuals) to make public comments for consideration by the State in developing the policy, quality standards, request for proposal, and 1915 waiver. Input received at that conference and subsequent community and advocacy group meetings were considered in the development of the current direction of the Medicaid managed care program.

HMOs contract with consumer and advocate organizations to provide education on HMO health systems and to facilitate enrollment and access to services. Consumers and guardians participate in consumer advisory boards. One BHMCO is in the process of organizing/funding a drop-in center operated by consumers.

Future Plans

Section 1915(b) - SALUD!: Future plans include expansion of the children's health initiative combined with extensive outreach to increase the number of children participating in the program.

★ *New Program Under Development:* New Mexico is beginning the process of designing a behavioral health managed care program funded by State dollars.

State Agency Administration

The Medicaid authority in New Mexico is MAD, within the Department of Human Services. The mental health authority is the Division of Mental Health. The substance abuse authority is the Division of Substance Abuse. Both are housed within the Department of Health.

Welfare Reform

The State's Temporary Assistance for Needy Families plan went into effect July 1, 1997. The plan stipulates denying benefits to drug felons but does not test recipients for drug use.

County

Not applicable.

Evaluation Findings

An external quality review contractor is beginning a review of the project.

Other Quantitative Data

Encounter data is required. Quarterly reports on utilization of specific services, on-site assessments, and review of case management processes have begun and will be continued.

NEW YORK

OVERVIEW

New York State's primary managed care initiative, an 1115 waiver program referred to as The Partnership Plan, is being implemented by the New York State Department of Health, the Office of Mental Health (OMH), and the Office of Alcoholism and Substance Abuse Services. Mandatory enrollment of Medicaid-eligible groups into basic health plans is occurring on a phase-in basis. The basic plans provide general health care benefits and limited mental health and substance abuse services. Upon certification by the Health Care Financing Administration (HCFA) of Special Needs Plans (SNPs), a mandatory phase of enrollment for adults with severe and persistent mental illness (SPMI) and children with severe emotional disturbance (SED) will occur in those counties where SNPs are located. There are exceptions to the mandatory enrollment in The Partnership Plan. Exceptions, based on certain criteria, include individuals whose participation would remain voluntary (i.e., exempt) and individuals who are excluded from participation in The Partnership Plan.

The State is also planning to develop an extended benefit package for Alcohol and Other Dependency (AOD) services, beyond the basic benefit plan coverage. The extended benefit package would be reimbursed on a fee-for-service (FFS) basis.

The Office of Alcoholism and Substance Abuse Services (OASAS) is operating several county-based demonstration programs using all sources of government funding including Federal, State, and local dollars as well as all income sources, to determine the best way to organize and deliver AOD services under managed care arrangements.

Also, the OMH is operating a managed care initiative for mental health services provided in State-operated facilities.

Managed Care Programs for Behavioral Health Services

MEDICAID WAIVERS

Section 1115 - The Partnership Plan - partial carve-out: Integrates basic mental health and substance abuse services. The SNPs carve out mental health services for those individuals who exhaust the basic benefits. Substance abuse services are available for enrollees of mainstream plans.

MEDICAID VOLUNTARY

None.

OTHER MANAGED CARE PROGRAMS

The Prepaid Mental Health Plan (PMHP) - mental health stand-alone: Mental health services provided in State-operated facilities; not established under a waiver; established as a health plan pursuant to Section 36A of the New York State Social Services Law.

County Demonstration Application on the Provision of Managed Addiction Treatment Services - substance-abuse stand-alone: OASAS developed plans for three or more time-limited demonstration programs. The demonstrations involve coordinated support from OASAS and State departments of health and social services to test and evaluate new methods or arrangements for organizing, financing, staffing, and providing services in order to determine the desirability of such methods and arrangements.

Geographic Location

Section 1115 - The Partnership Plan: Basic health plans are being phased in on a county-specific basis (currently implemented in 11 counties). SNPs for mental health services will be implemented in the future on a county-specific or regional county-consortia basis.

The PMHP: Statewide.

County Demonstration Application on the Provision of Managed Addiction Treatment Services: Erie and Albany counties.

Status of Programs

Section 1115 - The Partnership Plan: Submitted waiver March 20, 1995; waiver approved July 15, 1997. Draft request for proposal (RFP) for adults with serious mental illness released September 1997; final RFP for adult SNP anticipated late fall 1998 and contracts to be signed early 1999. Children's request for information (RFI) released April 29, 1998. Comments being analyzed and incorporated into final design of children's SNP program.

PMHP: Implementation April 1, 1996.

County Demonstration Application on the Provision of Managed Addiction Treatment Services: Phase I implementation October 1, 1997. Formal approval has been given to two of the four Phase I counties.

Medicaid Substance Abuse Services Remaining Fee-For-Service

Opiate treatment; outpatient (e.g., alcohol rehabilitation); inpatient (e.g., services provided by section number 1035 facilities).

Medicaid Mental Health Services Remaining Fee-For-Service

Rehabilitation (e.g., day treatment for children and adolescents, partial hospitalization for adults, continuing day treatment for adults, intensive psychiatric treatment); support (e.g., intensive case management).

Medicaid Substance Abuse Services in Managed Care Plan

Section 1115 - Partnership Plan: The basic benefit package includes acute detoxification, inpatient (up to 30 days; combined substance abuse/mental health benefit), outpatient (up to 60 visits). These services are not included in the basic health plan benefit package for Supplemental Security Income (SSI) recipients.

Medicaid Mental Health Services in Managed Care Plan

Section 1115 - Partnership Plan: The basic benefit package includes inpatient (up to 30 days; combined substance abuse/mental health benefit), outpatient (up to 20 visits). These services are not included in the basic health plan benefit package for SSI recipients.

The SNPs package for adults includes crisis services; rehabilitation; support (e.g., service coordination, self-help, and empowerment); inpatient; outpatient.

For children: Support (e.g., service coordination); crisis; inpatient; outpatient.

Non-Medicaid Substance Abuse Services in Managed Care Plan

PMHP: Not applicable.

County Demonstration Application on the Provision of Managed Addiction Treatment Services: All substance abuse treatment services as described by participating counties.

Non-Medicaid Mental Health Services in Managed Care Plan

PMHP: Mental health support (e.g., outreach, social training, socialization, supportive skills training, personal services, assessment, case management, clinical support, treatment planning, discharge planning, clinical support); crisis (e.g., intervention, respite, in-home support, psychiatric consultation); rehabilitation (e.g., psychiatric functional assessment, goal setting, service planning, resource development); inpatient; outpatient.

County Demonstration Application on the Provision of Managed Addiction Treatment Services: Not applicable.

Substance Abuse Prevention and Mental Health Promotion in Managed Care Plan

Section 1115 - The Partnership Plan: Basic health plans are required to do the following: develop policies and procedures to ensure that all network primary care providers routinely screen for mental health

and substance abuse programs; conduct formalized health screening to assess any behavioral health service needs of members; establish mechanisms to assess individuals at risk, provide outreach, and arrange for evaluations of their needs; adopt practice guidelines consistent with current standards of care; and ensure that members receive follow-up services from appropriate providers based on the findings of their assessment instruments.

PMHP: Personal support, self-help support, case management, education, health screening, and referral.

County Demonstration Application on the Provision of Managed Addiction Treatment Services: Counties may choose to provide supportive services beyond the spectrum of approved substance abuse services. Support may include educational activities related to prevention of future substance abuse by demonstration project participants.

Populations Covered Under Managed Behavioral Health

Section 1115 - The Partnership Plan: Adults and children mandatory: Aid to Families with Dependent Children/Temporary Assistance for Needy Families (AFDC/TANF), Home Relief (Safety Net population), and Medicaid-only recipients who reside in participating counties. SSI voluntary (see Future Plans Section).

Mental Health SNPs: See Future Plans Section.

PMHP: Voluntary adults and children: AFDC/TANF, SSI, individuals receiving inpatient, outpatient, or community support program (CSP) services at an Office of Mental Health (OMH) Adult Psychiatric Center, individuals currently not receiving licensed services at a non-State-operated program, individuals who meet the inpatient (ages 18-21 and over age 65) criteria and individuals who meet the outpatient criteria (over age 18).

County Demonstration Application on the Provision of Managed Addiction Treatment Services: Substance abuse clients. Additional covered populations depend on county initiatives.

State Managed Care Program Administration

Section 1115 - The Partnership Plan:

Basic Plan: The Department of Health (DOH) qualifies managed care organizations (MCOs) and prepaid health plans (e.g., Medicaid-only MCOs) to participate in Medicaid managed care programs.

The MCOs bid on a county or borough basis. Each bidder is required to address two separate areas: programmatic ability to serve the Medicaid population (technical proposal) and cost. Plans are encouraged to use community-based providers.

In evaluations of programmatic proposals, special weight is given to plans whose networks include linkages with community providers that have traditionally served the poor and uninsured, such as community health centers, federally qualified health centers, and school-based clinics.

Mental Health SNPs: The State expects to finalize the RFP for the adult mental health SNP in late fall 1998 and to execute contracts in early 1999 (see Future Plans Section). Under the SNPs, OMH and DOH provide joint certification, standards, rate setting, regulation, and oversight of the plans. Applicants for the plans can be any combination of persons, natural or corporate, including a county or counties.

AOD: Currently, participating MCO network providers (participating in a qualified partnership plan) submit claims to the MCO and the MCO reimburses the network providers at negotiated rates when

- an annual evaluation visit is requested by the patient (e.g., self-referral);
- assessment and treatment services have been ordered by the MCO, primary care provider, or other provider authorized by the MCO;
- assessment and treatment services are mandated by a court of competent jurisdiction. Network providers submit claims to the MCO, and the MCO reimburses network providers at negotiated rates. MCOs must reimburse non-network providers of court-ordered services at Medicaid rates; and
- the annual base benefit alcohol and chemical dependence services include up to 30 days of inpatient care and up to 60 outpatient visits for alcohol and chemical dependence treatment service.

PMHP: The purpose of this program is to provide an array of mental health services that best meet the needs of the recipient. State psychiatric centers serve as the managed care networks. None

have contracts with other providers. OMH maintains oversight authority.

County Demonstration Application on the Provision of Managed Addiction Treatment Services: OASAS and counties are partners in the goal of developing more innovative and effective approaches to delivering, to a targeted population, cost-effective addiction treatment services, health care, and social services in an effort to help clients achieve self-sufficiency.

Under State law, OASAS formally contracts with county governments for the provision of substance abuse services to meet their specific needs. County governments may provide services directly or contract with local providers for the delivery of services. The County Demonstration Project allows counties to apply management concepts and principles, which may include screening, assessment, referral, case monitoring, and different levels of case management, to specifically defined populations. Inherent in the demonstration is an evaluation component that will measure the effectiveness of county designs and ultimately assist OASAS in the development of a statewide model.

Financing of Plans

Section 1115 - Partnership Plan: This program is financed through Medicaid and State-only dollars. Under the Partnership Plan, MCOs are fully capitated and at risk. New York uses a bid and negotiation process for purposes of contracting with plans. The final contract rates negotiated must fall within rate ranges developed by actuaries who are under contract with the State. Actuaries use an FFS Medicaid claims database for developing FFS-equivalent rates that are trended forward to the current year. Rates are also adjusted for the impact of managed care on utilization and cost converted into ranges of acceptable rates. Savings were built into the capitation rate. Plans are required to be reinsured against insolvency; the state offers stop-loss coverage for this.

Mental Health SNPs: SNP contractors will be paid on a fully capitated basis with one possible exception: Rural counties electing to participate in the program may propose an alternative payment structure including, but not limited to, a partial capitation structure, subject to the approval of the State. The final RFP will be county specific and define the scope of the capitation payments and the payment levels.

A strong focus on the outcomes of care will be a major component of the SNP initiative. The State will use financial incentives to encourage appropriate levels of performance. Each year, the State will withhold a portion of the capitation payment in the range of 1 to 3 percent for performance incentives. The State, in conjunction with the localities, will identify annually one or more performance targets in key outcome areas of SNP performance. A SNP can recoup the withheld funds only by meeting or exceeding the performance targets.

Plans will not be responsible for the cost of inpatient expenses in excess of $100,000. Plans will continue to be responsible for managing and financing care but will be able to submit vouchers for FFS reimbursement for 85 percent of the cost of inpatient claims in excess of the $100,000 individual stop-loss limit.

Plans will have to demonstrate sufficient capital to fund development and preoperational costs, accumulated losses through break-even, and an allowance for contingencies. Each SNP will be required to demonstrate adequate capitalization to ensure the financial viability of the plan and must also establish a 5 percent statutory escrow reserve fund. Plans will be required to share gains with the State. Gain-sharing requirements will be determined on an annual basis.

PMHP: This program is a partially capitated Medicaid initiative. Capitation rates were determined based on historic Medicaid expenditures for services.

County Demonstration Application on the Provision of Managed Addiction Treatment Services: This program is financed through all sources of government funding, including Federal, State and local dollars as well as all income sources. Providers will continue to be paid on either an FFS basis or net deficit contracts. At this time, providers assume no risk; however, one aspect of the demonstration is to explore alternate means of financing.

Coordination Between Primary and Behavioral Health Care

Section 1115 - The Partnership Plan: Individuals enrolled in the SNP for their mental health services will be co-enrolled in a health plan for their physical health

services. Formal linkages will be critical to ensure the coordination of care. Agreements will be executed between the SNP and these organizations.

PMHP: Not applicable.

County Demonstration Application on the Provision of Managed Addiction Treatment Services: Under this program, MCOs will continue to provide physical health care services under their capitated rate.

Consumer-Family Involvement

Section 1115 - The Partnership Plan: The Medicaid Managed Care Advisory Council's Consumer Education Subcommittee was charged with the responsibility of ensuring that Medicaid clients are guaranteed accurate managed care information about issues such as service access and accessibility; grievance procedures; clients' bill of rights; how to choose the right plan; special needs concerns and processes; and enrollment and disenrollment procedures.

Mental Health SNPs: The Medicaid Managed Care Advisory Council's Mental Health Subcommittee met for 9 months. The Subcommittee was composed of a wide range of constituent representatives (e.g., recipients, families, providers, advocates, administrators) and was charged with developing recommendations for adult and children mental health SNPs. Since that time, the state has held many public meetings to discuss progress on program design and feedback.

Additionally, an advisory group, composed of members of various previous New York State Office of Children's Health subcommittees was formed to review

- the contents of the children's SNP RFI;
- the responses that are received during the public comment process; and
- the implications of that information for future children's SNP planning.

PMHP: Self-help is one of the five service categories in PMHP. Facilities are working with recipients to expand all help opportunities. Also, recipients serve as enrollment counselors for prospective enrollees.

County Demonstration Application on the Provision of Managed Addiction Treatment Services: The County Demonstration Project requires, as part of the application process, a signed assurance regarding public participation and plan dispute resolution. This assurance addresses the participation of local addiction providers, local social service providers, consumers, consumer groups, advocacy groups, and other local parties during the application process and throughout the course of the demonstration period.

Future Plans

Section 1115 - Partnership Plan: Regional phase-in of mandatory enrollment of AFDC/TANF and Home Relief (HR) populations will be statewide in approximately 3 years. SSI will be mandatorily enrolled when program features and rates are established. HCFA has stated that SSI can become mandatory in each region no sooner than 1 year after mandatory enrollment of TANF/HR, and only after certain milestones are achieved.

Currently, the inpatient limit for any combination of mental health and substance abuse services is 30 days. When the program features and systems capabilities are developed, this will change to 30 inpatient days for substance abuse services only, and the outpatient limit will change from 60 visits to 20 visits (e.g., benefit limit package).

Mental Health SNPs: Call letters have been issued to the counties, inviting individual counties or consortia of counties to submit a Letter of Intent as to their interest in having one or more SNPs sited in their county or counties. Letters of Intent were received from five geographic regions.

In the future, as SNPs are certified by HCFA, SPMI adults and SED children will be able to choose to obtain mental health services through a basic health plan or an SNP. Participation in SNPs would be limited to individuals who meet the definition of SPMI or SED (FFS exception: SPMI adults and SED children could continue to access mental health services on an FFS basis if they reside in a county that offers no SNP services, or in a county that offers only a county-operated SNP).

★ *New Program Under Development:* In the rest of the State, two possible regional SNPs have emerged: one for a 10-county region and one for a 19-county region. Other possible SNPs include one for Long Island and one covering Westchester County and other counties north of New York City.

★ *New Program Under Development:* An RFI was released in April 1998 for a children's SNP. This pro-

gram will serve those Medicaid-eligibles under age 18, on a voluntary basis, who meet diagnostic and utilization criteria.

PMHP: Services in an outpatient setting are expected to continue through 1998/2000. Continuation of PMHP beyond that has not been determined.

County Demonstration Application on the Provision of Managed Addiction Treatment Services: There is a Phase II round of applications with eight additional counties showing interest through the formal application process. OASAS staff are working to further develop proposals for implementation later in the year, in addition to the remaining Phase I counties.

State Agency Administration

The Medicaid, Mental Health, and Substance Abuse agencies are housed under three separate agencies: the Department of Health, OMH, and OASAS, respectively.

Welfare Reform

One of New York's Works Programs (part of welfare reform) is the Article VII Safety Net Program. This program provides temporary aid but no cash assistance. Persons eligible for the Safety Net include qualified aliens who enter the country on or after August 22, 1996, families who are ineligible for Family Assistance because of time-limit expirations, persons whose mental or physical impairment consists of substance abuse, and needy persons who do not reside with children. Those who are able to work will be required to participate in workfare and other employment services supervised by the Department of Labor.

The program requires that local social services departments, when there are reasonable grounds to believe that substance abuse is a material cause of economic dependency or a barrier to employment, enroll the applicant/recipient in a State-licensed or certified rehabilitation program, when available. Investigation into the cause of an applicant's condition shall include drug testing to assist in determining if habitual and unlawful use of drugs is a cause of economic dependency or a barrier to employment. If an applicant tests positive for drugs, he or she will be retested prior to payment of assistance or as soon thereafter as is practical. If the applicant is found to have continued to use drugs unlawfully, assistance to the household will be limited to the Safety Net. Failure to submit to testing will result in denial of assistance to the family. Periodic drug testing will be conducted with respect to recertifications of recipients for eligibility for public assistance; assistance to the households of persons found to be unlawfully using drugs will be limited to Safety Net assistance under a social services plan approved by the State Department of Social Services.

MCOs participating in The Partnership Plan are not responsible for the provision and payment of substance abuse treatment services provided to Medicaid managed care enrollees who have been mandated by the local department of social services to receive substance abuse services as a condition of eligibility for public assistance or Medicaid as a result of welfare reform. District-mandated welfare reform substance abuse services that are approved by the Office of Alcoholism and Substance Abuse Services, covered by Medicaid, and provided by a Medicaid-enrolled provider will be reimbursed on an FFS basis. Currently, this policy applies only to those individuals determined to have a substance abuse problem that is a material cause of economic dependency or a barrier to employment.

County

Not applicable.

Evaluation Findings

Section 1115 - Partnership Plan: SNPs in the first year of the program must use State-defined algorithms to quantify performance in seven broad categories: service access, service appropriateness, administrative efficiency, enrollee wellness, enrollee ability, enrollee social integration, and prevention.

- OASAS is in the process of implementing Phase IV of the Treatment Outcome Study, which has entailed a 3-year, four-phase process designed to evaluate the delivery of public alcoholism and drug abuse treatment services. The first of three phases focused on measuring the efficiency and effectiveness of treatment services and served as the foundation of the study. Phase IV will:
  - ➢ Examine the relationship between types and intensity of services and client outcomes;

- ➢ Assess the effectiveness of different types of programs in producing positive outcomes in clients with similar presenting problems; and
- ➢ Examine cost-benefit ratios of the New York drug and alcohol treatment system.

Preliminary data suggest immediate results from treatment. It is anticipated that most of the data will be available within 3 years. The first report, which will not require complete data submission, will address the relationships between services received and retention and discharge status and will probably be available in the fall of 1999. Smaller, focused outcome studies will be implemented in the future to address issues raised in the Treatment Outcome Study, or other issues of significance to OASAS (e.g., outcome of clients in Women and Children Programs, outcome of managed care clients). Much will depend on the availability of funds. An application is pending with CSAT for a Treatment Outcomes and Performance Pilot Studies II (TOPPS II) grant to examine the relationship between outcome and performance measures.

Other Quantitative Data

There are currently 628,025 Medicaid beneficiaries (29.1 percent of total eligibles) enrolled in 37 Medicaid managed care plans throughout New York State (data current as of May 1998).

The 12 provider-sponsored plans operating in New York City now serve more than half (56.4 percent or 219,467) of all enrollees. Statewide, 17 provider-sponsored plans serve 47.8 percent of all enrollees, some 299,964 individuals.

The Department of Health's Office of Managed Care maintains reports on managed care enrollment data and participating plans. The data change on a monthly basis. Interested parties can request quantitative information regarding managed care enrollments and from the Department of Health.

NORTH CAROLINA

OVERVIEW

Carolina Alternatives is North Carolina's single publicly operated behavioral health managed care program for Medicaid recipients. For nonpsychiatric care, Medicaid recipients participate in one of several primary health managed care programs.

Carolina Alternatives is a Medicaid waiver program that operates under the authority of Section 1915(b) of the Social Security Act. Carolina Alternatives is a publicly operated managed care program that provides mental health and substance abuse benefits to children and adolescents who are certified for Medicaid in a county that participates in the waiver. Carolina Alternatives operates on the local level through 10 area programs serving the 32 counties participating in the waiver. A waiver renewal application is currently being reviewed by the Health Care Financing Administration (HCFA) to allow continuation of the waiver in the current sites. Plans are to expand the waiver statewide to serve all Medicaid-eligible children and adults; however, a specific timetable for expansion has not been set.

Managed Care Programs for Behavioral Health Services

MEDICAID WAIVERS

Section 1915(b) - Carolina Alternatives - behavioral health stand-alone: Covers mental health and substance abuse services for children and adolescents (ages 0 to 18 years) on a capitated basis. Area Mental Health Centers are the portal of entry for services.

MEDICAID VOLUNTARY

Not applicable.

OTHER MANAGED CARE PROGRAMS

Not applicable.

Geographic Location

Section 1915(b) - Carolina Alternatives: Currently serving 32 out of 100 counties.

Status of Programs

Section 1915(b) - Carolina Alternatives: Submitted in March 1993; approved December 17, 1993; implemented January 1, 1994. Waiver was renewed in December 1995. A second waiver renewal application, submitted in May 1998, is currently being reviewed by HCFA.

Medicaid Substance Abuse Services Remaining Fee-For-Service

Acute detoxification; opiate treatment programs; outpatient (e.g., substance abuse day treatment); inpatient; crisis.

Medicaid Mental Health Services Remaining Fee-For-Service

Inpatient; outpatient (e.g., clinic services, case management, screening and evaluations, client behavior intervention, high risk intervention); Institution for Mental Diseases (IMD) services for individuals under age 21 and over age 65.

Medicaid Substance Abuse Services in Managed Care Plan

Section 1915(b) - Carolina Alternatives: Detoxification; outpatient (day treatment); inpatient for individuals under age 21; crisis (e.g., client behavior intervention, facility-based crisis, high-risk intervention).

Medicaid Mental Health Services in Managed Care Plan

Section 1915(b) - Carolina Alternatives: Inpatient; outpatient (e.g., case consultation, screening and evaluation, individual and group clinical services, partial hospitalization, day treatment, psychosocial rehabilitation, case management, assertive community treatment teams); crisis (e.g., client behavior intervention, facility-based crisis, high-risk intervention); IMD services for individuals under age 21 and over age 65.

Non-Medicaid Substance Abuse Services in Managed Care Plan

Not applicable.

Non-Medicaid Mental Health Services in Managed Care Plan

Not applicable.

Substance Abuse Prevention and Mental Health Promotion in Managed Care Plan

Section 1915(b) - Carolina Alternatives: High-risk intervention (HRI) and client behavioral intervention (CBI) services include early treatment, psychoeducation, and recreational activities designed to intervene in or reduce disability or dysfunctioning. Early intervention and treatment services also include education/training to the primary caregivers (e.g., family members, teachers). Services of this type are traditionally described as "secondary" prevention services. HRI and CBI services may be provided at any location. Carolina Alternative sites have developed the capacity to provide wraparound services to children or youth who, because of early symptoms or environmental factors, are at risk of developing mental health, substance abuse, or developmental problems, or are at risk of increasing the degree of their problems.

Populations Covered Under Managed Behavioral Health

Section 1915(b) - Carolina Alternatives: Children mandatory: Aid to Families with Dependent Children/Temporary Assistance for Needy Families (AFDC/TANF), Seventh Omnibus Budget Reconciliation Act (SOBRA) (e.g., Medicaid to infants and children, pregnant women), supplemental security income (e.g., disabled, blind), Title IV-E Adoption Subsidy/Foster Care, Foster Care-Non Title IV-E Foster Care.

State Managed Care Program Administration

Section 1915(b) - Carolina Alternatives: The Division of Medical Assistance has established an Memorandum of Agreement with the Division of Mental Health/Developmental Disabilities/Substance Abuse Services (DMH/DD/SAS), which contracts with qualified nonprofit area MH/DD/SAS programs (Area Authorities) to carry out the local coordination, delivery, and fiscal management of covered mental health and substance abuse services for eligible Medicaid recipients. Area Authorities may consist of a single county or multiple counties. Area Authorities are governed by an Area Board appointed by the County Commission in each of the counties included. They are mandated to oversee and coordinate behavioral health services, are at full risk, and are paid a capitated fee. Area Authorities pay providers directly for services rendered. Any interested and qualified provider is permitted to participate in the program.

New organizational entities have been developed to assist Area Authorities with their roles as managed care organizations (MCOs). These entities will be reviewed by DMH/DD/SAS as contract agencies if they provide services under contract to Area Authorities. Providers are reimbursed according to the rates negotiated in their contract with the area program. Implementation of Carolina Alternatives has enabled certain mental health practitioners (e.g., psychologists, social workers) who cannot bill Medicaid directly to be reimbursed for their services by participating in the Carolina Alternatives provider network.

The area program is the local MCO with direct responsibility for local implementation of the waiver. A statewide administrative services organization

(ASO) has been brought in to help Area Authorities attain economy of scale in carrying out certain managed care functions. Plans are for the ASO to perform credentialing and privileging, claims processing, and analysis of utilization data. These plans are still under review and have not been formalized yet.

Financing of Plans

Section 1915(b) - Carolina Alternatives: The Area Authorities function as the MCOs for the county or region that each one serves. As of January 1, 1996, the 10 participating Area Authorities have been at full financial risk for both inpatient and outpatient services for enrollees. Area Authorities receive a capitated rate for each eligible child. The original capitation rates were based on historical use of inpatient services and an estimate of outpatient services. The rates used for 1997 were calculated from data collected from the first 2 years of implementation with adjustments made to meet cost-effectiveness requirements and adjustments toward a statewide mean rate. The rate of payment is that rate negotiated in the subcontract except in the following cases: 1) where emergencies or authorized referrals to out-of-area or nonaffiliated providers occur, the Area Authority shall be liable for payment only to the amount paid by Medicaid to fee-for-service (FFS) providers, and 2) in the case of the transition from FFS to contracted service, the provider has the responsibility to follow the Transition of Services guidelines; the Area Authority will then be responsible for payments (at the Medicaid rate) to Medicaid providers for enrollees in pre-existing services until the Area Authority has either defined a transfer plan or negotiated different payment arrangements. The capitation has been set by MH/DD/SAS at a rate lower than the FFS equivalent. New capitation rates for continuation of the waiver have not been set.

Coordination Between Primary and Behavioral Health Care

Section 1915(b) - Carolina Alternatives: Medical histories are required as part of any client's initial assessment for service needs. Care planning teams and case managers are encouraged to work with primary care providers (PCPs) to ensure coordinated services. Expanded provider networks include psychologists and social workers who share offices with PCPs, providing continuity for children whose health needs are met in the same office. Special attention has been given to coordination of the Carolina Alternatives waiver with the primary care through participation in workshops and conferences and the development of publications explaining the interface of Carolina Alternatives with various target groups (e.g., public health social workers), the Work First welfare reform initiatives, and the Medicaid primary care waiver programs.

Consumer-Family Involvement

Section 1915(b) - Carolina Alternatives: Area Authorities' approaches to integrating consumer and family views have been varied. Approaches taken by Area Authorities include 1) establishing interagency "prevention" review committees with community involvement; 2) involving community members in interagency communication plans to improve wraparound services; 3) publishing and distributing monthly newsletters; 4) establishing the Carolina Alternatives Policy Advisory Committee (CAPAC), a group of stakeholders who advise the Division on policy matters. Groups throughout the State, representing various consumer groups, advocacy groups, providers, and professional associations, participate in CAPAC. Formation of CAPAC in 1996 was a significant turning point in the State's public sector program. CAPAC developed a set of working principles concerning the manner in which civil discourse and policy making should occur. Consumers have affected several very difficult policy areas. CAPAC consumers helped draft a consumer brochure, copies of which are distributed to all Medicaid enrollees in participating Carolina Alternatives counties. CAPAC consumers helped draft an updated appeal policy and set of guiding principles assuring consumers of their Federal fair hearing rights. Consumer groups actively participated in the implementation of the appeal policy. Groups attended an appeal training session, convened by the Division, with area program staff. Consumer groups staff toll-free support lines and field questions about Carolina Alternatives appeal policy and the program in general. Consumers also helped CAPAC develop a policy requiring area programs to offer consumers a choice of service providers in the Carolina Alternatives area program networks. Recently, consumers participated in draft-

ing the Carolina Alternatives Adult Levels of Care Criteria. Their participation in this technical document reflects the exceptional commitment and perseverance of North Carolina consumers. This partnership is essential to giving consumers a voice.

Future Plans

Section 1915(b) - Carolina Alternatives: An application for continuation of the Carolina Alternatives in the current sites is currently being reviewed by HCFA. The State eventually plans to phase in Carolina Alternatives and expand the waiver to include adults. A timetable for expansion and adult implementation has not been set.

State Agency Administration

The Department of Health and Human Services houses the Medicaid authority (the Division of Medical Assistance) and the mental health and substance abuse authority (DMH/DD/SAS).

Welfare Reform

The State's TANF program became effective on January 1, 1997. The program stipulates denying benefits to certain drug felons and allows for the testing of recipients for drug use. The program is based on the statewide welfare reform initiative that has been operating since June 1995 and was strengthened by waivers in 1996. The State's TANF program is called Work First. Three provisions for substance abuse are the following: providing early childhood services when substance abuse is identified to ensure the healthy development of children in these families; stationing qualified substance abuse counselors in county offices to provide screening, assessment, employment readiness, and treatment referral; and ensuring that existing treatment programs provide self-sufficiency skills and vocational support for individuals with substance-abuse-related impairments. A common alcohol/drug-screening tool has been instituted. Selected sites will be involved in an enhanced employee assistance program to work with employers who have agreed to employ substance-abusing TANF clients to help them maintain sobriety and be successful in the workplace.

County

Not applicable.

Evaluation Findings

A client satisfaction survey conducted by the DMH/DD/SAS suggests that 66.7 percent of clients felt the program helps them a great deal; 80.6 percent of respondents felt that program staff always treated them with respect; 76.3 percent of respondents felt that the facilities used were always clean and comfortable; 62.4 percent of respondents felt that they were involved in making decisions about their treatment all of the time; and 26.8 percent responded this was the case most of the time; and 64.1 percent of respondents were "very satisfied" with the program, and 29.3 percent responded they were "mostly satisfied."

Other Quantitative Data

Section 1915(b) - Carolina Alternatives: From 1994 to 1997, the number of children receiving services under Carolina Alternatives increased from 7.5 percent of the eligible Medicaid population being served to 8.5 percent. This compares with only 5.3 percent of Medicaid-eligible children receiving mental health or substance abuse treatment in 1992, before the waiver was implemented, and a penetration rate of 6.4 percent in 1997 for nonwaiver sites. The number of children served doubled from 1992 to 1997, from 5,149 children served to 11,265.

The average number of inpatient days per enrollee served decreased from 50.1 days in 1992 to 19 days in 1997. The average number of inpatient days per child decreased from 49.6 days per child in 1992 to 18.8 days per child in 1997. In 1992, almost 74 percent of the Medicaid dollars in waiver sites were spent on inpatient services. In 1997, only 12.3 percent of the dollars were spent on inpatient services. Actual dollars spent on inpatient services decreased by half from $11.8 million to $5 million in 1997.

A report released by the Office of State Budget and Management suggests Carolina Alternatives was effective in reducing hospitalization of new clients.

From January 1996 through January 1997 the Medicaid capitation rate for Carolina Alternatives remained unchanged but the per-eligible cost in the non-Carolina Alternatives area programs continued to rise by between 25 percent and 30 percent, according to Division of Health calculations.

NORTH DAKOTA

OVERVIEW

The majority of behavioral health services are currently in the fee-for-service system in North Dakota. Mental health and substance abuse services are not included in North Dakota's statewide primary care case management (PCCM) waiver program for physical health services; however, an amendment to the 1915(b) waiver implemented a pilot project in one county that integrates physical health, mental health, and substance abuse services under a full-risk Medicaid managed care program.

Managed Care Programs for Behavioral Health Services

MEDICAID WAIVERS

Section 1915(b) - North Dakota Access and Care (NoDAC) - integrated: Under a statewide PCCM program, physical health, mental health, and substance abuse in one county only.

MEDICAID VOLUNTARY

Not applicable.

OTHER MANAGED CARE PROGRAMS

Not applicable.

Geographic Location

Section 1915(b) - NoDAC: Grand Forks County.

Status of Programs

Section 1915(b) - NoDAC: Amendment implemented November 1, 1997.

Medicaid Substance Abuse Services Remaining Fee-For-Service

Inpatient; outpatient (e.g., clinic services).

Medicaid Mental Health Services Remaining Fee-For-Service

Inpatient; outpatient (e.g., clinic services, partial hospitalization); Institution for Mental Diseases services for individuals age 65 and over and age 21 and under; mental health rehabilitation (e.g., targeted case management).

Medicaid Substance Abuse Services in Managed Care Plan

Section 1915(b) - NoDAC: Inpatient; outpatient (e.g., clinic services).

Medicaid Mental Health Services in Managed Care Plan

Section 1915(b) - NoDAC: Inpatient; outpatient (e.g., clinic services, partial hospitalization); mental health rehabilitation (e.g., targeted case management).

Non-Medicaid Substance Abuse Services in Managed Care Plan

Not applicable.

Non-Medicaid Mental Health Services in Managed Care Plan

Not applicable.

Substance Abuse Prevention and Mental Health Promotion in Managed Care Plan

Section 1915(b) - NoDAC: None.

Populations Covered Under Managed Behavioral Health

Section 1915(b) - NoDAC: Voluntary adults and children: Aid to Families with Dependent Children/ Temporary Assistance for Needy Families (AFDC/ TANF), poverty-level women and children.

State Managed Care Program Administration

Section 1915(b) - NoDAC: The Department of Human Services (Medicaid) contracts with Northern Plains Health Plan, a North Dakotan health maintenance organization (HMO). The HMO is at full risk for all medical services in the contract, including substance abuse and mental health services. AFDC-related and poverty-level-eligible recipients have the option of enrolling in the HMO or remaining in the PCCM program. The purpose of the pilot is to determine if a "capitated" managed care approach is feasible in a rural State like North Dakota and to determine if this concept should be expanded to other eligible Medicaid groups and other geographical areas of the State.

Financing of Plans

Section 1915(b) - NoDAC: This program is funded by Medicaid dollars. The managed care organization is at full risk and capitated. Capitation rates were based on recipients' aid category, gender, and age.

Coordination Between Primary and Behavioral Health Care

Section 1915(b) - NoDAC: The pilot managed care contract in Grand Forks County requires all services including substance abuse and mental health services, to be coordinated through a primary care provider.

Consumer-Family Involvement

Section 1915(b) - NoDAC: Consumer and family involvement depends upon the providers' practice policies.

Future Plans

Section 1915(b) - NoDAC: None.

★ *New Program Under Development:* The Department of Human Services, Mental Health Division, is planning to submit a waiver to the Department of Health and Human Services for the carve-out of mental health services for children in three regions in the State. This limited program would integrate the services started by the Partnership Grant program. Preliminary work has been initiated.

State Agency Administration

The Medicaid, mental health, and substance abuse authorities are all under the Department of Human Services. The Medicaid authority is the Division of Medical Services; the mental health and substance abuse authorities are under the Division of Mental Health and Substance Abuse Services.

Welfare Reform

North Dakota's TANF plan became effective July 1, 1997. The program denies benefits to drug felons but does not test recipients for drug use.

County

Not applicable.

Evaluation Findings

Not applicable.

Other Quantitative Data

Not applicable.

OHIO

OVERVIEW

Although Ohio has not implemented a full carve-out for behavioral health, several other managed care initiatives are in place that affect public sector mental health and substance abuse services. Ohio has a Section 1115 waiver in 16 counties that provides some behavioral health services to Aid to Families with Dependent Children/Temporary Assistance for Needy Families (AFDC/TANF) and Healthy Start populations, along with the full Medicaid benefit package of physical health services. A voluntary pilot program in two counties also provides Medicaid services for people with disabilities. Additionally, Ohio hires a private contractor to perform utilization review for inpatient psychiatric services under Medicaid.

Managed Care Programs for Behavioral Health Services

MEDICAID WAIVERS

Section 1115 - OhioCare - general health - integrated: Provides the full range of Medicaid covered services. A carve-out arrangement specific to behavioral health (Transfer Services Carve-Out) was originally planned but has been put on hold.

MEDICAID VOLUNTARY

Accessing Better Care (ABC) - general health - integrated: A voluntary pilot program in two counties for people with disabilities and chronic illness that provides the full range of Medicaid-covered services.

OTHER MANAGED CARE PROGRAMS

URIP (Utilization Review for Inpatient Psychiatric services) - Medicaid program - mental health stand-alone: Utilization review program.

Geographic Location

Section 1115 - OhioCare: Mandatory enrollment in seven counties (Butler, Cuyahoga, Franklin, Hamilton, Lucas, Montgomery, and Summit) and voluntary enrollment in nine (Clark, Greene, Lorain, Mahoning, Miami, Pickaway, Stark, Trumbull, and Wood). A request for proposals (RFP) has been released to begin mandatory enrollment in these nine counties, effective October 1, 1998.

ABC: Franklin and Hamilton counties.

URIP: Statewide.

Status of Programs

Section 1115 - OhioCare: Submitted March 2, 1994; approved January 17, 1995; implemented July 1, 1996.

ABC: Implemented June 1, 1995.

URIP: Coordinated by mental health and contracted to specialty vendor in October 1996.

Medicaid Substance Abuse Services Remaining Fee-For-Service

Inpatient; ambulatory detoxification; outpatient (e.g., counseling, case management, intensive outpatient); crisis; opiate treatment programs (e.g., methadone maintenance).

Medicaid Mental Health Services Remaining Fee-For-Service

Inpatient; outpatient (e.g., clinic services, individual and group counseling, psychotherapy); crisis; mental health support (e.g., community support program); Institution for Mental Diseases services for individuals under age 22 and over age 65.

Medicaid Substance Abuse Services in Managed Care Plan

Section 1115 - OhioCare: Inpatient; acute detoxification; outpatient (e.g., counseling); opiate treatment programs (e.g., methadone maintenance).

ABC: Medicaid benefit package for acute care services, including inpatient services; opiate maintenance therapy.

URIP: Not applicable.

Medicaid Mental Health Services in Managed Care Plan

Section 1115 - OhioCare: Inpatient; outpatient (e.g., clinic services, counseling, psychotherapy).

ABC: Inpatient services; outpatient (e.g., clinic services, individual and group counseling, psychotherapy); crisis; mental health support (e.g., community support program).

URIP: Inpatient (utilization review).

Non-Medicaid Substance Abuse Services in Managed Care Plan

Not applicable.

Non-Medicaid Mental Health Services in Managed Care Plan

Not applicable.

Substance Abuse Prevention and Mental Health Promotion in Managed Care Plan

Section 1115 - OhioCare: Prevention services are encouraged as a primary goal of managed care.

ABC: Prevention services are encouraged as a primary goal of managed care.

URIP: Not applicable.

The Ohio Department of Alcohol and Drug Addiction Services (ODADAS) created the Wellness/Health Promotion Work Group to recognize prevention services as a value-added component to the full continuum of care. The goal is to integrate substance abuse prevention and early intervention services into a managed care arena. The work group serves in an advisory capacity to ODADAS on substance abuse prevention issues, provides oversight in the development of an evaluation framework and marketing strategies for prevention providers, and makes recommendations regarding prevention as related to managed care. ODADAS contracted with Conwal, Incorporated to develop and begin implementation of a marketing plan for community-based prevention providers establishing linkages with managed care.

Populations Covered Under Managed Behavioral Health

Section 1115 - OhioCare: Mandatory children and adults in seven counties and voluntary children and adults in nine counties: AFDC/TANF/Healthy Start.

ABC: Children and adults voluntary: Supplemental Security Income.

URIP: Not applicable.

State Managed Care Program Administration

Section 1115 - OhioCare: The Ohio Department of Human Services (ODHS) contracts with 13 health maintenance organizations (HMOs) (8 for-profit, 5 not-for-profit), which are at full financial risk for the entire range of Medicaid-covered services, including inpatient hospital. HMOs are selected through a competitive RFP process. Some HMOs subcontract out behavioral health services, and some have both direct subcontractors and a behavioral health management company. The plan is responsible for covering medically necessary, Medicaid-covered mental health and substance abuse services. Enrollees can self-refer to mental health and substance abuse services that are available through community providers—these services are not covered by HMOs. ODHS passes federal Medicaid funds to the Ohio Department of Mental Health (ODMH) and ODADAS to fully pay, on a cost-reimbursement basis, for these behavioral health services. Payment is then made through the Medicaid Community Mental Health Program, which is administered by ODMH, or the Medicaid Community Substance Abuse Treatment Program, which is administered by ODADAS.

ABC: ODHS contracts with a not-for-profit HMO, which then contracts with an academic medical center. The HMO is not at full risk; there is a risk corridor in place with an annual settlement. The provider network is established by the HMO in accordance with program requirements.

URIP: ODHS contracted with ODMH for all utilization review of psychiatric hospital inpatient services provided to Medicaid recipients. ODMH competitively bid out the services and hired a private contractor, who subcontracts certain services out to a mental health provider. The primary contractor is responsible for developing medical necessity criteria for inpatient psychiatric admissions, developing on-site postpayment review, offering intensive case or facility reviews, and facilitating provider appeals and recipient hearings, among other things. The subcontractor provides the precertification function as well as day-to-day functions.

Financing of Plans

Section 1115 - OhioCare: Medicaid is the sole source of funds for this program. ODHS pays each HMO a predetermined, monthly capitation payment for each Medicaid enrollee. ODHS requires HMOs to limit their liability for inpatient hospital services through stop-loss coverage that is activated when an enrollee incurs aggregate inpatient hospital claims in excess of $75,000 per year. The Community Medicaid Mental Health and the Alcohol and Other Drug Treatment programs are financed by the respective state agencies on a fee-for-service (FFS) basis.

Capitation rates are annually or semi-annually based on the FFS costs of an actuarially equivalent nonenrolled population in a prior (base) year, adjusted for trend, drug rebate, geographic region, age, sex and aid category, and discounted by 6 percent. An actuary under contract to ODHS has developed the rates in accordance with upper payment limit requirements.

ABC: Medicaid is the source of funds for this program. The HMO is paid a capitation rate, established for seven cost "categories" or "ranges" based on the historical FFS costs of the eligible population in a base year, trended forward, and adjusted for drug rebate. "Old" eligible—those with 6 months or more of Medicaid enrollment in the prior fiscal year—are assigned to a rate category based on their prior-year expenditures. An eighth capitation rate is established for "new" eligible—those with less than 6 months Medicaid claims history—and is calculated based on the average FFS costs of all "new" eligible in a prior year. This rate is adjusted for the average case mix of the population enrolled in the seven cost categories. There are no stop-loss provisions, but rather risk corridors. Administrative costs are capped at 10 percent of medical costs. There is a three-tiered risk-sharing arrangement for medical costs. HMOs are at risk for 90 percent of the first 5 percent; 50 percent of the next 10 percent; and 10 percent of anything over 15 percent of profit or loss.

URIP: Medicaid transfers funds to the DMH, which pays the contractor a set fee.

Coordination Between Primary and Behavioral Health Care

Section 1115 - OhioCare: Behavioral health services are provided by or referred by the client's primary care physician, who coordinates behavioral and physical health care services, or clients can self-refer to the community mental health or substance abuse treatment systems. Efforts to coordinate primary health and behavioral health services are occurring at both State and local levels. On the local level, HMOs, Alcohol, Drug Addiction, and Mental Health/Alcohol and Drug Addiction Services (ADAMH/ADAS) boards, and behavioral health care providers have developed care coordination agreements. Development of these care coordination plans is required in the ODADAS and ODMH community. Medicaid agreements with their respective boards, and in ODHS provider agreements with the HMOs. On the state level, coordination of activities among ODADAS, ODMH, and ODHS occurs regularly and is formally supported in interagency agreements.

ABC: Services are coordinated the same as they are under the Section 1115 waiver.

URIP: Not applicable.

Consumer-Family Involvement

Section 1115 - OhioCare: ODMH, ODADAS, and ODHS have communicated with many constituent groups in the State for several years regarding Medicaid behavioral health care.

ABC: An advisory committee was established for ABC that included families and consumers, who assisted in planning and implementation activities.

URIP: Not applicable.

Future Plans

Section 1115 - OhioCare: All voluntary counties will become mandatory on October 1, 1998.

ABC: Future plans are currently under evaluation.

URIP: Not applicable.

★ *New Program Under Development:* Ohio hopes to build upon the existing community systems of care by introducing specialty managed care to the list of services currently administered by ODHS. The intention is that eventually these services will be fully integrated with other publicly funded mental health and addiction services through contracts with ODMH and ODADAS, so as to create a coordinated and seamless system of mental health and addiction services.

State Agency Administration

The Medicaid authority is the Office of Medicaid, within ODHS. The mental health authority is ODMH. The substance abuse authority is ODADAS.

Welfare Reform

State plan under P.L. 104-193, filed with the U.S. Department of Health and Human Services on September 19, 1996, became effective October 1, 1996. Under the State's plan for TANF, no changes in Medicaid eligibility were instituted. The plan denies benefits to drug felons and requires prenatal drug screening, assessment, and treatment for pregnant Medicaid recipients in mandatory managed care counties. This mandatory drug screening aspect of welfare reform requires active collaboration between ODHS, ODADAS, HMOs, and ADAMH/ADAS boards and providers.

Prior to passage of the Federal Personal Responsibility and Work Opportunity Reconciliation Act, Ohio began reforming its welfare system through passage of House Bill 167, which went into effect in August 1995. The creation of Ohio Works First (OWF), which went into effect October 1, 1997, brought further reform. OWF is designed to help people become self-sufficient citizens and take personal responsibility for their lives, with a strong emphasis on obtaining and retaining employment. A number of core services are guaranteed to OWF participants statewide, including employment services, child care, and Medicaid. The OWF legislation indicates that substance abuse addiction treatment services provided by a program certified by ODADAS are to be included in the definition of "Allowable Alternative" Work Activities that county departments of human services are to establish and administer for OWF minor heads of households and adult participants. The OWF legislation also describes the substance abuse assessment process for determining other assistance or services to be provided to OWF participants, as well as for ascertaining whether any other member of the assistance group has a substance abuse problem. The law specifies that the county department of human services may refer participants for any assistance or services that the agency considers appropriate, such as Alcoholics Anonymous, Narcotics Anonymous, or Cocaine Anonymous. Ohio Medicaid reimburses for medically necessary substance abuse assessment and treatment services.

Benefits are limited to 3 years of cash assistance, followed by 2 years of ineligibility; participants may then apply for up to 2 years of benefits if they show good cause. County commissioners are to enter into Partnership Agreements with ODHS, in which the state agrees to provide funding for programs and administration, and counties are measured based on performance. Communities have the option to design and deliver public assistance services. Medicaid health care services have not devolved at the Federal level. Mandatory managed care counties have local coordination agreements between the HMOs and ADAMH/ADAS boards that have been filed with the State.

The 59 ADAMH/ADAS boards continue to explore the development of managed care tools; the State is monitoring this process.

As of September 1997, Hamilton County implemented a 5-year contract with a private, for-profit managed behavioral health care organization (MBHCO) to manage the delivery of behavioral health services to child welfare clients. Approximately $3.2 million per year will be spent for the information system, training, and administrative costs for the management of the program. Substance abuse services will use the MBHCO initially to handle only its administrative, billing, and information functions. The goal is to provide a seamless system of care. ODHS, ODMH, and ODADAS Medicaid services remain as they have

been described elsewhere because Medicaid is not a part of this arrangement.

The Franklin County ADAMH Board is proposing to implement a case rate approach to begin operation within the next 6 months. There will be six case rate tiers based on historical use. The project is targeted to begin operation in January 1999 but will affect only non-Medicaid-funded services. This issue is under current review.

County

Not applicable.

Evaluation Findings

Section 1115 - OhioCare: Since July 1, 1996, HMOs have been required to submit encounter data to ODHS on a monthly basis. A committee that included HMO representatives selected a number of performance measures that pertain to perinatal care, care of children, and mental health care. The measures are based on Health Employer Data and Information Set (HEDIS) measures, with some variations. These measures, in conjunction with member satisfaction surveys and other tools, are being used to evaluate the performance of HMOs in meeting the needs of Medicaid recipients. ODHS has calculated the performance measurement results for State fiscal year 1997 and will soon be issuing a report to the HMOs which outlines the results.

ODHS is also pursuing a comprehensive quality agenda. In addition to monitoring the HEDIS measures, ODHS is looking at consumer complaints and satisfaction, having recently conducted a consumer satisfaction survey. Looking at the particular behavioral health care needs of consumers and how these needs are being met is another important area that needs to be examined. ODHS desires to pursue a similar kind of quality agenda with statewide measures if the Medicaid behavioral health care system becomes integrated.

ODHS also contracts with an external quality review organization (EQRO). The EQRO conducts an annual independent assessment of the quality of services delivered to Medicaid recipients enrolled in Medicaid-serving HMOs. The EQRO evaluates whether the administrative processes of the HMOs comply with state administrative rules and conducts quality care studies.

The following areas have been targeted for study: childhood immunizations; prenatal care; early and periodic screening; diagnostic and treatment services (EPSDT); childhood asthma; and dental care. The EQRO is also looking at adult depression. ODHS has urged the community behavioral health system to explore the merits of having a statewide EQRO assess the quality of community mental health and substance abuse treatment services.

Other Quantitative Data

Encounter data, including those related to the ABC program, have been collected from the HMOs since July 1, 1996. Additionally, the HMOs provide aggregate utilization data to ODHS on a quarterly basis. A research grant to perform an evaluation of the ABC program was awarded to Case Western Reserve University. The evaluation will consider utilization of services, length of enrollment in the program, variations in case mix by county, consumer satisfaction, and the predictive reliability of risk-adjusted capitation rates. The evaluation is not yet complete.

OKLAHOMA

OVERVIEW

Oklahoma's existing Medicaid waiver program, entitled SoonerCare, encompasses two distinct managed care initiatives: SoonerCare Plus and SoonerCare Choice. Eligibility for these programs is contingent upon both Medicaid eligibility and geographic area of residence. SoonerCare Plus is a fully capitated health care model implemented in three of the most populous areas of the State. SoonerCare Plus includes behavioral health services with an enhanced benefit package for individuals identified by the Oklahoma Health Care Authority (OHCA) (the State Medicaid agency) to have special mental health needs (serious mental illness/severe emotional disturbance (SMI/SED)). Behavioral health series under SoonerCare Plus are provided by contracted health maintenance organizations (HMOs). The second initiative, SoonerCare Choice, is a primary care case management (PCCM) program implemented in the remaining areas of the State. Behavioral health services under this program remain in the fee-for-service (FFS) system.

Managed Care Programs for Behavioral Health Services

MEDICAID WAIVERS

Section 1115 - SoonerCare:

SoonerCare Plus - integrated: Fully integrated HMO model that includes an enhanced benefit package for individuals determined by the OHCA to have special mental health needs (SMI/SED).

SoonerCare Choice - general health - PCCM model: Behavioral health services remain in the FFS system.

MEDICAID VOLUNTARY

Not applicable.

OTHER MANAGED CARE PROGRAMS

Not applicable.

Geographic Location

Section 1115 - SoonerCare - SoonerCare Plus: Oklahoma City, Tulsa, Lawton, and surrounding counties.

Status of Programs

Section 1115 - SoonerCare - SoonerCare Plus: Submitted December 1994; approved by the Health Care Financing Administration October 1995; protocol approved December 1995, effective January 1, 1996; implemented February 1996.

Amendment to include SMI/SED on voluntary basis submitted and approved January 1997; implemented July 1, 1997. Amendment to include SMI/SED on mandatory basis submitted November 1997; approved April 1998; to be implemented July 1, 1998.

Medicaid Substance Abuse Services Remaining Fee-For-Service

Substance abuse services, covered through the Medicaid FFS program, vary for children and adults. Services are pre-authorized for one of four levels of care ranging from limited outpatient to intensive outpatient care.

Substance abuse services for adults include inpatient (12 maximum inpatient days per year for all inpatient stay needs, including physical and behavioral health care stays—this includes detoxification); outpatient (e.g., individual, family, group, and rehabilitative treatment).

Substance abuse services for children include outpatient (e.g., hospital-based day treatment; individual, family, group, and rehabilitative treatment);

therapeutic foster care; acute detoxification (only when medically necessary).

Medicaid Mental Health Services Remaining Fee-For-Service

Mental health services for adults include outpatient, mental health support, and mental health rehabilitation. Children's mental health services include inpatient, residential, outpatient, mental health support, and mental health rehabilitation.

Medicaid Substance Abuse Services in Managed Care Plan

Section 1115 - SoonerCare - SoonerCare Plus: For all SoonerCare Plus members: outpatient (e.g., individual, family, and group treatment, evaluation, and testing); detoxification (only when medically necessary), residential (e.g., for pregnant women and their children).

Medicaid Mental Health Services in Managed Care Plan

Section 1115 - SoonerCare - SoonerCare Plus: For non-SMI/SED members: inpatient; outpatient; (e.g., individual, family, and group therapy, day treatment, evaluation, and testing); crisis.

For SMI/SED members, the above services in addition to intensive outpatient services; rehabilitation (e.g., psychosocial services, case management); residential (e.g., home-based services); crisis (e.g., mobile assessment); mental health support (e.g., in-home, peer counseling); therapeutic foster care (children only).

Non-Medicaid Substance Abuse Services in Managed Care Plan

Not applicable.

Non-Medicaid Mental Health Services in Managed Care Plan

Not applicable.

Substance Abuse Prevention and Mental Health Promotion in Managed Care Plan

Section 1115 - SoonerCare - SoonerCare Plus: Early and periodic screening, diagnosis, and treatment (EPSDT).

Populations Covered Under Managed Behavioral Health

Section 1115 - SoonerCare - SoonerCare Plus: Mandatory adults and children: Aid to Families with Dependent Children/Temporary Assistance for Needy Families (up to 45 percent Federal poverty level).

State Managed Care Program Administration

Section 1115 - SoonerCare - SoonerCare Plus: Under the OHCA, SoonerCare Plus contracts with private, nonprofit HMOs that provide services through their networks. Some of the SoonerCare HMOs directly provide the behavioral health care management. For Year IV of SoonerCare Plus (July 1, 1998–June 30, 1999), three of the four HMOs subcontract, at least partially, behavioral health care management to separate entities. In order to ensure that essential community providers participate in the provider network, health plans are required by the OHCA to offer contracts equal in scope and reimbursement to the essential community providers, including the 19 community mental health centers (CMHCs) in Oklahoma. The health plans contract with other behavioral health care providers in addition to the CMHCs that participate.

Three of the four SoonerCare Plus HMOs contracted for Year IV subcontract behavioral health care management. Two of the HMOs subcontract all behavioral health management, and one HMO subcontracts behavioral health management in one service area and retains internal management for the other service area.

The behavioral health organizations' subcontracts fulfill the OHCA's requirements for behavioral health service provision by SoonerCare Plus providers. Services contracted include, but are not limited to utilization review, encounter data development, assessment and recommendation for SMI/SED determination, referral of behavioral health services for plan members, monitoring of provider network, coordination of services for SMI/SED members (including mandatory case management and assessments), and maintaining quality assurance.

The annual contracting process for SoonerCare Plus includes issuance of a request for proposals (RFP) by the OHCA, review of written bids and

responses to the RFP, award of SoonerCare Plus contracts, completion of readiness reviews for each awarded health plan, and completion of annual operational compliance audits of each SoonerCare Plus health plan. In addition, the OHCA Behavioral Health Services Unit assesses requests for SMI/SED determinations from the health plans and responds to formal and informal grievances from behavioral health care providers and members.

Financing of Plans

Section 1115 - SoonerCare - SoonerCare Plus: Under SoonerCare, HMOs are fully capitated and at risk. Medicaid dollars finance the program. HMOs are paid a capitated rate based on FFS historical costs using actuarial calculations.

The OHCA has established two capitation rates for SMI/SED population, one for adults (age 21 and over) and a second for children (under age 21). The same adult and child rates will be paid to all health plans across all service areas. It should be noted that these rates are inclusive of all care, not just the behavioral health care provided to the SMI or SED. The actual capitation rate amounts are as follows: Adults age 21 and over: $229.31 per member per month; children under age 21: $751.12 per member per month.

In developing capitation rates, the OHCA relied on historical FFS claims for SMI/SED individuals disenrolled from health plans since the start of the SoonerCare Plus program. The data was adjusted to account for changes made to the FFS program early in State fiscal year 1997, including adoption of new payment rates and a prior authorization system for behavioral health services.

The cost of services for SMI/SED members, in the aggregate, is compared to the total capitation paid for those members. The health plan and the OHCA share the risk based upon the percentage of gains or losses in specified risk-sharing corridors.

The OHCA made capitation payments to the health plans on a monthly basis via electronic funds transfer. The OHCA issues a prepaid, per member, per month amount as payment in full for any and all covered services provided to the member. Capitation payments are member-specific and appropriate to the member's rate category.

Coordination Between Primary and Behavioral Health Care

Section 1115 - SoonerCare - SoonerCare Plus: In SoonerCare Plus the plans are responsible for all care and are evaluated on coordination of care concerns.

Consumer-Family Involvement

Section 1115 - SoonerCare - SoonerCare Plus: Consumers and consumer advocacy associations have assisted in the development of SoonerCare through focus groups, membership on various task forces, and ongoing dialogue with OHCA staff. The OHCA released an invitation to bid for a consumer-based advocacy program to provide education and advocacy services for Medicaid recipients designated SMI/SED. A contract for this program has not been awarded. Currently, consumer education and assistance is provided by the OHCA Behavioral Health Services Unit. In addition to other outreach efforts, the OHCA facilitates monthly meetings with consumer advocacy organizations in an effort to maintain positive relations with behavioral health consumers and advocates.

Future Plans

Section 1115 - SoonerCare - SoonerCare Plus: Under this waiver, State legislation mandates aged, blind, and disabled enrollment in managed care by July 1, 1999. The OHCA is actively developing the framework and specifics of the future managed care services and delivery system for those Medicaid recipients. Internal and external planning meetings are being held regularly. The population will most likely be noninstitutionalized, non-dually-eligible (Medicare/Medicaid), non-State-custody (children) Medicaid recipients statewide.

In addition, the existing urban geographic boundaries for inclusion in SoonerCare Plus may expand, but there is no definite established timeline.

For the rural population being served in the PCCM model, a co-existing and complementary behavioral health managed care program may be developed and initiated over the next year.

★ *New Program Under Development:* The Department of Mental Health and Substance Abuse Services (DMHSAS) has designed a pilot managed care project that will provide behavioral health services to non-Medicaid recipients in DMHSAS-sup-

ported or -contracted facilities. Implementation of this program is pending resolution of funding and design barriers. No proposed implementation date has been identified.

Ultimately, the intent of this program is to generalize the managed care system to the entire state pending the outcome of the project. Functions performed by the technical services vendor will be transitioned to DMHSAS or its provider networks. In the second and subsequent years, one or more provider networks may be selected to organize and manage services for the defined priority populations. Specific report card/outcome indicators have been developed as evaluation tools for this pilot project.

★ *New Program Under Development:* The Department of Human Services (DHS), Division of Children and Family Services (DCFS) has requested money through the state to provide technical assistance in the development of a child welfare managed care system. Such a system would ensure a continuum of service delivery for DHS-custody children and their families. The goal for a managed child welfare system would be to maximize funding streams to enhance benefits, develop provider networks, and improve quality of services. DCFS currently outsources with a variety of private vendors for an array of clustered services.

State Agency Administration

OHCA is the State agency responsible for Oklahoma's Medicaid program. DMHSAS houses the Mental Health and Substance Abuse agencies.

Welfare Reform

Oklahoma's Temporary Assistance for Needy Families (TANF) program became effective October 1, 1996. It does not require drug testing of all TANF-eligibles; it does deny TANF benefits to those individuals convicted of drug felonies.

Oklahoma has received waivers from Health and Human Services to operate two welfare reform demonstrations under Title IV-A, Section 1115 of the Social Security Act: Oklahoma Learnfare Project and Mutual Agreement—A Plan for Success. The State indicates it will continue its two-county Learnfare waiver until its completion.

County

Not applicable.

Evaluation Findings

Section 1115 - SoonerCare - SoonerCare Plus: OHCA monitors the health plans through the use of Health Employer Data and Information Set (HEDIS) 3.0.

Other Quantitative Data

Not applicable.

OREGON

OVERVIEW

Oregon's Medicaid managed care program—the Oregon Health Plan (OHP)—includes coverage for mental health and substance abuse services statewide for both Medicaid and non-Medicaid populations. Substance abuse services are fully integrated into the OHP, since prepaid health plans have responsibility for these services statewide. After a pilot carve-out, mental health benefits were gradually integrated statewide into the OHP. Currently, mental health is integrated in eight counties, and there is a carve-out provider in all counties.

Additionally, the State is implementing a demonstration to integrate intensive mental health with physical health services for children under OHP.

Managed Care Programs for Behavioral Health Services

MEDICAID WAIVERS

Section 1115 - OHP - general health - integrated: Includes mental health and substance abuse services.

MEDICAID VOLUNTARY

Not applicable.

OTHER MANAGED CARE PROGRAMS

Children's Intensive Mental Health Treatment Services - integrated: The Office of Mental Health Services, Mental Health Developmental Disabilities Services Division (MHDDSD) is developing an initiative to pilot the integration of children's intensive mental health treatment services into OHP mental health organizations (MHOs).

Geographic Location

Section 1115 - OHP: Statewide.

Children's Intensive Mental Health Treatment Services: Unknown.

Status of Programs

Section 1115 - OHP: Approved March 19, 1993; implemented February 1, 1994; outpatient substance abuse services placed under managed care May 1, 1995; mental health services phased in January 1, 1995 in 20 of the 36 counties; remaining counties phased in October 1, 1997. As of January 1, 1998, all 36 counties in Oregon have OHP mental health services under managed care, even those that have filed legal challenges.

Children's Intensive Mental Health Treatment Services: The pre-pilot began October 1, 1997, and will run until September 30, 1998.

Medicaid Substance Abuse Services Remaining Fee-For-Service

Outpatient; opiate treatment

Medicaid Mental Health Services Remaining Fee-For-Service

Adults and children: Inpatient, outpatient, pharmacy, mental health support, mental health rehabilitation.

Children only: Residential.

Medicaid Substance Abuse Services in Managed Care Plan

Section 1115 - OHP - Chemical dependency benefits include outpatient; opiate treatment.

Medicaid Mental Health Services in Managed Care Plan

Section 1115 - OHP: Mental health services include only inpatient; Institution for Mental Diseases services for individuals under age 21 and over age 65; outpatient; mental health support; mental health rehabilitation; crisis; pharmacy.

The MHO provides all medically necessary and appropriate mental health services covered by the capitation payment for the 38 funded mental health conditions appearing on the list of prioritized health services. MHOs are also required to cover the cost of care in acute inpatient psychiatric programs for individuals, except individuals needing long-term care or who require State hospitalization.

Non-Medicaid Substance Abuse Services in Managed Care Plan

Children's Intensive Mental Health Treatment Services: Not applicable.

Non-Medicaid Mental Health Services in Managed Care Plan

Children's Intensive Mental Health Treatment Services: Outpatient (e.g., day treatment); residential (e.g., psychiatric).

Substance Abuse Prevention and Mental Health Promotion in Managed Care Plan

Section 1115 - OHP: The State requires each prepaid health plan to meet a total of 21 conditions, including one for prevention and education services. Capitated services include mental health services formerly provided under early and periodic screening, diagnosis, and treatment (EPSDT) for children.

Children's Intensive Mental Health Treatment Services: None.

Populations Covered Under Managed Behavioral Health

Section 1115 - OHP: Mandatory adults and children: Aid to Families with Dependent Children/ Temporary Assistance for Needy Families, pregnant women and children under age 12 (170 percent of Federal poverty level (FPL)), Supplemental Security Income (SSI), dual eligible (Medicare/Medicaid).

Children's Intensive Mental Health Treatment Services: Children in state custody, foster children, children with severe emotional disturbance.

State Managed Care Program Administration

Section 1115 - OHP: The Oregon Department of Human Resources (DHR) is the single State agency responsible for Medicaid and the Oregon Health Plan. The Office of Medical Assistance Programs (OMAP) has primary responsibility for the oversight and administration of the Section 1115 waiver. The offices and divisions of OMAP work collaboratively with the Office of Alcohol and Drug Abuse Programs (OADAP) and the MHDDSD in the planning, development, implementation, monitoring, and evaluation activities related to integrating mental health and chemical dependency services.

Chemical dependency benefits: For the provision of health and substance abuse services, the State (Medicaid) contracts with fully capitated health plans (FCHPs) and physician care organizations (PCOs). FCHPs include health maintenance organization (HMOs) and other provider network organizations. PCOs are multipractitioner prepaid health plans that deliver or arrange for health care services. PCO clients in need of mental health services are referred to MHOs.

The OADAP requires that at least 50 percent of FCHP members who need chemical dependency services receive those services from State-approved facilities (in most locations, however, it is actually closer to 100 percent). These providers are independent providers that are approved by the State as meeting quality assurance standards and rules issued by the State.

Mental health benefits: The State currently operates a hybrid model for mental health services under OHP by contracting with both county carve-out plans (MHOs) and fully capitated health plans (HMOs). In September 1997, when the state issued the request for proposals (RFP) to roll out mental health statewide, it included a preference for county mental health agencies by accepting private carve-out proposals only in areas where a county chose not to apply. Balancing this against the need to ensure movement toward contracting with "full-service managed care organizations" per state

stature, the RFP contained a "viability determination" for carve-out MHOs.

During the evaluation of the RFP responses, the State announced a quantifiable standard to address the viability issue: that each awarded MHO carve-out have a minimum of 50 percent of Medicaid-eligible covered lives available. The State used this standard in determining whether one or more contracts could be awarded within a county. In the majority of counties, the State has designated one contractor as the MHO; however, in 8 of the 36 counties statewide, the State contracts with both HMOs and MHOs, establishing county mental health agencies and HMOs as competing MHOs.

MHOs cover 88 percent of the Medicaid lives and contract independently or on a regional basis with the State Mental Health Division.

The Mental Health Division contracts with 13 organizations statewide. Three are local mental health authorities that applied independently to provide mental health services within their county boundaries. Two are private MHOs, one of which is a consortium of 17 rural Oregon counties where the local mental health authorities continue to provide the mental health services for their counties. Three more are regional county mental health consortiums, and five are fully capitated health plans (HMOs) that provide the mental health benefit for their physical health plan enrollees in selected counties. These HMOs currently subcontract with mental health/behavioral health organizations to provide the mental health services to their enrollees.

In reaction to the statewide roll-out of OHP, three counties in Oregon have filed circuit court petitions to reverse the State's decision on contract awards for its capitated Medicaid mental health program. Unlike legal challenges in other states, this one comes from traditional players in the public mental health system. All three of the counties were selected under the statewide implementation plan but are disputing the use of fully capitated health plans to share responsibility for mental health services in the counties. The counties charge that the state violated regulations governing the procurement process by failing to follow the stated criteria of the RFPs and making an award based on proposals from unqualified bidders. Thus far, all three cases have been consolidated under one judge and are pending.

Children's Intensive Mental Health Treatment Services: OMHS will contract with day and residential treatment providers and therapeutic group homes. OMHS will provide technical assistance and modify contracts with pilot providers to ensure that pilot projects have the necessary fiscal and contractual flexibility to redesign and restructure delivery systems at current funding.

The role of providers will likely be as subcontractors with the MHOs. The Division will contract with the MHOs directly and they in turn will subcontract with the "Intensive" providers. Most of the providers are private nonprofits with several public entities.

Financing of Plans

Section 1115 - OHP: OHP is financed through Medicaid and State general funds.

Chemical dependency benefits: FCHPs (HMOs) are paid a capitated rate for most health services in the benefit plan, including substance abuse (residential detoxification is fee-for-service) and assume full financial risk for them. The capitation rate is per member per month. One FCHP provides services directly with some subcontracting, and the other subcontracts for all services.

Mental health benefits: MHOs are fully capitated and at risk and receive a monthly per member per month capitation payment from the MHDDSD for each enrolled OHP-eligible person. The MHO is required to protect itself against loss either by self-insuring or by obtaining stop-loss protection from a private insurer. The capitation rates are based on historic fee-for-service claims adjusted for eligible groups for which the State did not have fee-for-service claims history. A private actuarial firm calculated the rates in a manner consistent with the medical-surgical rates.

HMOs receive a separate capitation payment for mental health. There are two separate (physical health and mental health) contracts with different rates. If the HMO subcontracts for mental health or substance abuse services, the HMO/MHO determines how the subcontractor is paid. Currently, all of the HMOs that also contract as MHOs subcontract with specialty MHOs to manage their mental health benefit on a capitated basis. Some of the

HMOs also include chemical dependency and Medicare in these subcontracting arrangements.

Children's Intensive Mental Health Treatment Services: Not yet finalized.

Coordination Between Primary and Behavioral Health Care

Section 1115 - OHP: Coordination of services is mandated in OHP contracts, but methods for accomplishing the task vary greatly throughout the State. MHDDSD and the Office of OHP Policy and Research are currently collecting data on this issue.

Children's Intensive Mental Health Treatment Services: Coordination of services is mandated in the contract but methods for accomplishing the task vary greatly throughout the State. MHDDSD and the Office of OHP Policy and Research are currently collecting data on this issue. This process is still being finalized.

Consumer-Family Involvement

Section 1115 - OHP: During the design phase, consumer and family representatives played a key advisory role on the statewide planning and management council in developing OHP. They have played a larger role in implementation. From 1997 to 1999, contractors are required to include consumers on advisory bodies and quality improvement councils. MHOs have consumer and family representation on their quality assurance committees. Several have hired consumers as ombudsman–consumer affairs officers. Likewise, many family members have been hired as family advocates. Globally, the perspective of consumers and families is being more thoroughly integrated into the delivery system.

Children's Intensive Mental Health Treatment Services: Pilots will work collaboratively with family representatives in the design and implementation of their projects. Thus far, family advocates have been involved in the planning of the demonstration.

Future Plans

Section 1115 - OHP: OMAP is planning to use Health Employer Data Information Set (HEDIS) indicators to monitor the quality of plans and use encounter data submitted by plans to help set and validate rates.

Oregon is expanding efforts for substance abuse clients to provide up to 14 hours per week outpatient care under OHP. Those placed in residential care will be paid for by a separate mechanism: through a State tax on beer and wine.

★ *New Program Under Development:* The Legislative Emergency Board granted a request by Oregon's OMAP January 29, 1998, to form two study groups to examine the Oregon Medicaid proposal for greater oversight of 10 mental health drugs. At the end of 6 months the State Medicaid office will decide what type of oversight program, if any, it will put before the Board. The drugs to be reviewed are three antipsychotics—Clozaril, Zyprexa, and Risperdal—and seven antidepressants—Prozac, Zoloft, Paxil, Wellbutrin, Effexor, Serzone, and Luvox.

★ *New Program Under Development:* The Oversight Task Force on Mental Health Integration was created under executive order by the Governor "to monitor all aspects of the transition of mental health services to managed care." Membership is diverse and includes two members of the Oregon State Legislature. The Task Force is studying the effects of integration. Work is scheduled to be completed by December 31, 1998.

The Task Force, through a metro-area subcommittee and a southern Oregon subcommittee, has examined several tentative contract offers that were made by the division and were subject to Task Force review and recommendations. The Task Force recommended that no new contracts be implemented at this time. The MHDDSD has implemented this recommendation and will work with current contractors on a variety of implementation issues. MHDDSD does not intend to pursue another procurement process until July 1, 2001, at the earliest. The Task Force will now focus on other policy and implementation issues, such as improved coordination between mental health and primary care and between mental health and chemical dependency providers.

Children's Intensive Mental Health Treatment Services: Pilot is scheduled to run from October 1, 1998, through December 31, 1999. Full integration will occur on January 1, 2000.

★ *New Program Under Development:* Oregon plans to use federal funds for uninsured children to expand the Medicaid and subsidy programs. The

benefit package will be the same as OHP's and will include the mental health benefit. This effort is estimated to cost $23 million over the next 2 years to target working families who cannot afford premium cost-sharing under their employer's plan. The program has been approved and enrollment is set to begin July 1, 1998. The benefit package will be the same as under the OHP, and will include the mental health benefit. The population included initially will be children through age 19 (approximately 16,800 children) up to 170 percent FPL, with expansion to 200 percent FPL at a later date.

State Agency Administration

Oregon's Medicaid, Mental Health, and Substance Abuse agencies are housed under one department, the DHR. OMAP, MHDDSD, and OADAP are the respective agencies.

Welfare Reform

In 1992, Oregon received a welfare reform waiver through Title IV-A, Section 1115 of the Social Security Act, which among other things, requires Job Opportunities and Basic Skills (JOBS) participants to engage in various treatment programs, including mental health and substance abuse diagnostic, counseling, and treatment programs. The substance abuse and mental health components of Oregon's JOBS program are provided within the context of a JOBS program that aims to move recipients into the labor market as quickly as possible and within the context of a welfare system that emphasizes job placements rather than the provision of cash assistance as its primary mission.

Oregon has relied on both administrative and policy changes to shift the emphasis of welfare reform from the provision of cash assistance to employment. Three administrative changes are especially important to the implementation of the waiver allowing substance abuse or mental health treatment to be mandated for JOBS clients: 1) using case managers, 2) emphasizing up-front job search and self-sufficiency planning, and 3) relying on a labor force attachment model.

Funding for mental health and substance abuse treatment services for welfare recipients is included in the overall budget for the JOBS program which is financed with State lottery and general fund dollars. These funds are allocated by the State legislature and matched to Federal funds. The districts then decide how much of their overall allocation will be spent to provide substance abuse and mental health services, allowing local districts to develop service systems that respond to the needs of their recipients and take into account variation in local services delivery systems. These mental health and substance abuse services are "wraparound services" that cover needs not met by the health plans under the Medicaid managed care program, OHP. Treatment is provided through the OHP. Mental health services for JOBS program participants are included in OHP mental health capitation rates. MHO contractors are required to work collaboratively with adult and family services district managers to ensure that the mental health needs of participants are appropriately met, including education, screening, and treatment.

County

Section 1115 - OHP: Twenty-three counties operate carve-out plans. Examples of these plans are described below.

Fully Capitated Health Plans:

Family Care, Regence HMO Oregon, ODS, and Tuality Health Alliance are all fully capitated health plans. The plans provide physical and mental health benefits to their enrollees. As HMOs and MHOs, Family Care, ODS, and Regence each cover four counties; Tuality Health Alliance is in one county. Three of these subcontract with the same behavioral health organization to provide the mental health benefit, and several also subcontract with other MHOs to provide mental health services to enrollees.

Carve-Outs: County Governments/Regional Organizations:

Accountable Behavioral Health Alliance is a county government carve-out that covers four counties: Benton, Deschutes, Jefferson, and Lincoln. Services are provided by the local mental health authorities and a variety of private practitioners.

Jefferson Behavioral Health is a county government carve-out that covers six counties: Coos, Curry, Douglas, Jackson, Josephine, and Klamath. Services are provided by the local mental health authorities.

Mid-Valley Behavioral Care Network is a county government carve-out that covers five counties: Linn, Marion, Polk, Tillamook, and Yamhill. Services are provided by the local mental health authorities and a variety of private practitioners.

Clackamas County MHO is a local mental health authority/county mental health plan (LMHA/CMHP) that uses a closed provider panel for direct provision of most outpatient mental health services, but may use nonpanel providers under special circumstances. Clackamas MHO also contracts with local hospitals for acute inpatient psychiatric services using declining daily rates.

LaneCare is an MHO that is part of Lane County LMHA/CMHP and uses an established provider panel for direct provision of most outpatient mental health services. LaneCare has a partnership with an FCHP to provide administrative support primarily in the areas of claims payment, data management, and completion of contractually required reports.

CAAPCare in Multnomah County is an MHO that is part of the LMHA/CMHP and uses an established provider panel for direct service provision for most outpatient mental health services. CAAPCare also contracts with local hospitals for acute inpatient psychiatric services.

Private Carve-Outs:

Providence Health Systems is a private organization that was selected as the carve-out for Washington County. Providence also subcontracts with ODS to provide the mental health services for enrollees in Washington County.

Greater Oregon Behavioral Health Incorporated (GOBHI) is a partnership model of county mental health programs and uses its own members and contract providers to deliver outpatient mental health services. It also contracts with Eastern Oregon Psychiatric Center (a state facility) and two private hospitals for acute inpatient psychiatric services. GOBHI serves Baker, Clatsop, Crook, Gilliam, Grant, Harney, Hood, River, Lake, Malheur, Morrow, Sherman, Umatilla, Union, Wallowa, Wasco, and Wheeler Counties. In these 17 counties, the OHP-eligible person is enrolled with and receives mental health services from the single behavioral health organization serving the county. GOBHI covers members in Columbia County which is also served by Regence HMO Oregon and Family Care, two FCHP/MHOs that contract with CEES to manage the mental health and chemical dependency benefit for their members.

Evaluation Findings

Section 1115 - OHP: Although not specifically related to mental health or substance abuse, recent findings from a 1997 evaluation were as follows: The number of services covered under Medicaid was reduced; managed care cost more per eligible person than FFS; Medicaid eligibility was expanded; length of stay and inpatient bed days decreased; use of services increased; and there was general satisfaction with services.

A separate study conducted by Michael Finigan (independent contractor) concluded that for every dollar Oregon spent on substance abuse treatment for all recipients, $5.60 was saved on other social services. Clients who completed these treatments earned 65 percent more income than clients in a comparison group. These individuals were also 45 percent less likely to be arrested and half as likely to be investigated for child abuse or neglect.

Oregon's Office of Mental Health Services recently gathered survey data on consumer satisfaction related to managed care. This data is currently under review. The survey is based in part on the national Mental Health Statistics Improvement Program (MHSIP) Consumer-Oriented Mental Health Report Card. Oregon recently completed a Stage I and II Federal MHSIP Grant, and the final report is currently under draft. The State is now working on an MHSIP State Reform Grant. The preliminary findings show general satisfaction in both the adult and child systems. A complete analysis and report has yet to be done.

Other Quantitative Data

Not applicable.

PENNSYLVANIA

OVERVIEW

Pennsylvania is progressing with implementation of its mandatory-enrollment Medicaid managed care program, HealthChoices, which features a physical health program operated by health maintenance organizations (HMOs) and a behavioral health component operated by counties. Under the HealthChoices behavioral health program, counties have right of first opportunity to manage the behavioral health Medicaid program. Counties have the further option of establishing their own behavioral health managed care organization (BHMCO) or subcontracting with a private sector BHMCO. The southeast part of the State was the first to implement this program. All but one of the five southeast counties are subcontracting with private, for-profit managed care organizations (MCOs). The remaining county, Philadelphia, has formed its own nonprofit organization to manage care.

The State is preparing to implement the program in ten southwest counties beginning January 1, 1999. It is currently negotiating with three individual counties and a six-county partnership, and should begin implementation in 1999. Eight out of ten counties plan to subcontract behavioral health services to a private, for-profit MCO. Allegheny County plans to subcontract to a private, nonprofit consortium of mental health and substance abuse providers. One county did not submit a proposal, and the State will contract directly with a private sector MCO.

In some areas where HealthChoices has not been implemented, the State operates a voluntary HMO program and primary care case management (PCCM) programs. The voluntary HMO program includes basic behavioral health services and clients enrolled in the PCCM programs self-refer to mental health and/or substance abuse services.

P

Managed Care Programs for Behavioral Health Services

MEDICAID WAIVERS

Section 1915(b) - HealthChoices Behavioral Health Services (HCBHS) - behavioral health stand-alone: Behavioral health services are delivered on a capitated basis.

MEDICAID VOLUNTARY

Voluntary HMO Contracts - general health - integrated: Operational in 28 counties; behavioral health services are included in 11 of those counties.

OTHER MANAGED CARE PROGRAMS

Not applicable.

Geographic Location

Section 1915(b) - HCBHS: Five southeast counties (Philadelphia, Bucks, Chester, Delaware, and Montgomery). Ten more counties are expected to implement in the southwest part of the State before January 1999. Statewide implementation will be phased in.

Voluntary HMO Contracts: Allegheny, Armstrong, Beaver, Berks, Blair, Butler, Cambria, Cumberland, Dauphin, Erie, Fayette, Greene, Indiana, Jefferson, Lackawanna, Lancaster, Lawrence, Lehigh, Luzerne, Mercer, Monroe, Northampton, Northumberland, Schuylkill, Somerset, Washington, Westmoreland, and York Counties.

Status of Programs

Section 1915(b) - HCBHS: Submitted March 1996; approved December 31, 1996; implemented February 1, 1997.

Voluntary HMO Contracts: Implemented January 1, 1972. Will be phased out when HealthChoices is implemented statewide.

Medicaid Substance Abuse Services Remaining Fee-For-Service

Acute detoxification; inpatient (e.g., rehabilitation); outpatient; opiate treatment programs (e.g., methadone maintenance).

Medicaid Mental Health Services Remaining Fee-For-Service

Not applicable.

Medicaid Substance Abuse Services in Managed Care Plan

Section 1915(b) - HCBHS: Detoxification (e.g., non-hospital residential and rehabilitative inpatient detoxification); inpatient; outpatient (e.g., partial hospitalization); mental health rehabilitation (e.g., behavioral mental health rehabilitation for children and adolescents, targeted case management, family-based mental health services for children and adolescents); crisis; mental health residential (e.g., residential treatment facility (RTF) for children and adolescents).

Voluntary HMO Contracts: Detoxification; inpatient (e.g., rehabilitation); outpatient (including partial hospitalization).

Medicaid Mental Health Services in Managed Care Plan

Section 1915(b) - HCBHS: Inpatient; outpatient (e.g., partial hospitalization); mental health rehabilitation (e.g., behavioral mental health rehabilitation for children and adolescents, targeted case management, family-based mental health services for children and adolescents); crisis; mental health residential (e.g., RTF for children and adolescents).

Voluntary HMO Contracts: Outpatient (including early and periodic screening, diagnosis, and treatment (EPSDT) wraparound); inpatient (e.g., intensive care facilities, extended psychiatric hospitals), mental health rehabilitation (e.g., RTFs).

Non-Medicaid Substance Abuse Services in Managed Care Plan

Not applicable.

Non-Medicaid Mental Health Services in Managed Care Plan

Not applicable.

Substance Abuse Prevention and Mental Health Promotion in Managed Care Plan

Section 1915(b) - HCBHS: EPSDT services. Coordination with primary care providers on screens for early identification of problems, and if a medical issue is identified, the behavioral rehabilitation services are offered.

Voluntary HMO Contracts: EPSDT.

Populations Covered Under Managed Behavioral Health

Section 1915(b) - HCBHS: Children and adults mandatory: Aid to Families with Dependent Children/Temporary Assistance for Needy Families (AFDC/TANF), expanded coverage for pregnant women and children, Supplemental Security Income (SSI), general assistance. General assistance populations are funded by State-only and Federal general assistance. Gross income limits vary by county: The gross income limit in Philadelphia and Delaware Counties is $551. The limit for Bucks, Chester, and Montgomery Counties is $579.

Voluntary HMO Contracts: Children and adults voluntary: AFDC/TANF, Federal general assistance, SSI (without Medicare), State-only categorically needy and medically needy.

State Managed Care Program Administration

Section 1915(b) - HCBHS: The Office of Mental Health and Substance Abuse Services (OMHSAS), within the State Department of Public Welfare (DPW), contracted with five southeast counties to administer the behavioral health managed care program in their areas. Four of the counties contracted with a private, for-profit behavioral health MCO to handle day-to-day program operations. Philadelphia County established a nonprofit organization to implement the program.

In the southwest region, OMHSAS plans to contract with three individual counties as well as a group of six counties, which submitted a proposal collectively. Allegheny County will subcontract behavioral health out to a consortium of mental health and substance abuse providers. Fayette and Beaver counties, as well as the six counties proposing together, are subcontracting their behavioral health services to a for-profit BHMCO. The State plans to contract directly with a private, for-profit MCO in one county area that did not submit a bid.

Voluntary HMO Contracts: The Medicaid agency contracts with for-profit and nonprofit HMOs on a capitated basis. Rates are negotiated on an annual basis. The HMOs contract with primary care physicians and specialty providers. Referrals are required for mental health and substance abuse services. All HMOs subcontract behavioral health services.

Financing of Plans

Section 1915(b) - HCBHS: Federal Medicaid and State general funds finance the program. As the primary contractor, the county is at risk for all medically necessary behavioral health in-plan service payments; it receives a capitated per-member per-month (PMPM) payment. Although four of the counties have transferred portions of this risk to their subcontractors, the counties retain ultimate fiscal responsibility. Stringent fiscal solvency requirements are contained in the State's contracts with the counties.

Funds are blended at the State level. The southeast counties pay the behavioral health MCOs on a PMPM basis. Actuarially sound rate ranges were developed, and rates were negotiated within the range.

Voluntary HMO Contracts: Medicaid contracts with HMOs who are at full financial risk and receive a PMPM capitated payment. Rates reflect a negotiated percentage for the PMPM cost to provide benefits to a fee-for-service Medical Assistance Control population. The control population is divided into recipient groups on the basis of age, gender, and Medicaid program eligibility information, as well as county groups. The control population includes fee-for-service recipients whose enrollment into an HMO program is permitted by DPW policy. The State compiles the historic cost of the control population and applies changes that reflect trends in utilization and average price along with policy changes, to compute the PMPM cost to provide benefits during the agreement year. Payment provided by the agreement does not exceed the upper payment limit of what it would have cost the department to provide the same services under fee-for-service to an actuarially equivalent population.

Coordination Between Primary and Behavioral Health Care

Section 1915(b) - HCBHS: The HealthChoices program contains detailed requirements for coordination between the BHMCOs and the HMOs responsible for the physical health component of the HealthChoices program. Written agreements between the HMOs and BHMCOs must include provisions governing referral and coordination of emergency and nonemergency treatment; clinical information exchange, consultation, and training; and clinical and fiscal dispute resolution.

Voluntary HMO Contracts: BHMCO subcontractors coordinated behavioral health services. Primary care physicians coordinate care.

Consumer-Family Involvement

Section 1915(b) - HCBHS: There was very strong consumer, family, and other stakeholder involvement in the development of the HealthChoices behavioral health carve-out. Leadership came from a united, broad-based coalition of county commissioners, mental health and drug abuse administrators, statewide and local consumer and family-member organizations, and consumer advocates. Consumers and family members participated in the State evaluation of the proposals and served on the readiness review teams.

In the southeast, consumers, family members, and advocates participate on several committees including Medical Assistance Coordinating Committee; Integrated Health Services Subcommittee; Behavioral Health Managed Care Advisory Committee; HealthChoices Southeast Consumers; Persons in Recovery; and Family Members of Behavioral Health Advisory Committee.

Consumers and family members participate in the on-site monthly monitoring teams. The Consumer Satisfaction Teams directly monitor the

provision of services and report their findings to the county. Consumers and family members are also required to have input in the development of the reinvestment plans submitted by the counties.

In the southwest, consumers, family members, and persons in recovery are required to have documented input into the development of the county request for proposals (including the selection committee) in the event that the county chooses to partner with a private BHMCO. Consumers, family members, and persons in recovery participated in the State's review of the proposals submitted for the HealthChoices program and will participate in the Readiness Reviews to be conducted prior to program implementation.

Voluntary HMO Contracts: None.

Future Plans

Section 1915(b) - HCBHS: DPW will implement the program in the southwest in 1999. The program will be rolled out in 10 counties in the Lehigh-Capitol region the following year.

Voluntary HMO Contracts: Of the current 28 counties within the voluntary program, 10 will become mandatory as of January 1, 1999. The remaining voluntary programs may expand into the 34 counties with no managed care program depending on the timing of implementation of HealthChoices. Once HealthChoices is implemented in any county, it replaces the voluntary program.

State Agency Administration

The State's mental health and substance abuse authority resides in OMHSAS, which is housed in the DPW. The Office of Medical Assistance Programs, the State's Medicaid authority, is also under the DPW. There is a second, separate Bureau of Drug and Alcohol Program (BDAP), which is within the Department of Health. OMHSAS coordinates with the BDAP in designing and monitoring the HealthChoices program.

Welfare Reform

Pennsylvania's TANF plan was filed with the U.S. Department of Health and Human Services (DHHS) on January 22, 1997. It went into effect March 3, 1997. The plan stipulates denying benefits to drug felons and tests its recipients for drug use once an individual has been identified as needing treatment following an initial assessment.

On July 31, 1997, Pennsylvania submitted another 1115 waiver to DHHS. This waiver is intended to help welfare recipients get into the work force. The program, entitled Common Sense Welfare to Work Project, emphasizes work and personal responsibility and encourages people to become more self-sufficient.

County

The Integrated Delivery Network (IDN) for Youth and Families is being developed in cooperation with Allegheny County Department of Human Services. The pilot project, which involves 30 children entering residential care, is scheduled to be implemented soon in Pittsburgh. Providers will receive an annual case rate.

Evaluation Findings

For the voluntary HMO program, annual reviews are conducted by the external quality review independent contractor. As the State moves forward with mandatory managed care, voluntary programs will mirror the same reporting requirements as the mandatory programs. Encounter data has been collected, which includes age groupings, diagnosis, eligibility group, expenditures, and category of services. Information is also being collected on performance outcome measures.

Other Quantitative Data

Not applicable.

RHODE ISLAND

OVERVIEW

Rhode Island operates two managed care programs that affect behavioral health. The State operates a physical health managed care program for Aid to Families with Dependent Children/Temporary Assistance for Needy Families (AFDC/TANF) populations, RIteCare, which aims to improve health services for low-income women and children through expanded Medicaid eligibility and increased access to physical health services as well as limited mental health and substance abuse services. This program excludes children with severe emotional disturbance (SED) and severe and persistent mental illness (SPMI) adults with serious mental illness (SMI). For detoxification services, the State Department of Health contracts with a substance abuse treatment provider to manage services, funded by block grants and general revenue.

A program for specialty mental health is on the horizon. It will be a pilot program for disabled individuals not included in the RIteCare program. A request for proposals (RFP) has been completed, and the State has completed its initial selection process for partners for the program.

Managed Care Programs for Behavioral Health Services

MEDICAID WAIVERS

Section 1115 - RIteCare - general health - integrated: Provides primary and preventive care including mental health and substance abuse treatment, but services for adults with SMPI and SED children are carved out.

MEDICAID VOLUNTARY

Not applicable.

OTHER MANAGED CARE PROGRAMS

Detoxification services - substance abuse stand-alone: Provides detoxification services funded through block grants and general revenue.
RICover - mental health stand-alone: Pilot project for disabled populations.

Geographic Location

Section 1115 - RIteCare: Statewide.

Detoxification services: Statewide.

RICover: Initial implementation will be in the four attachment areas in the central portion of the State.

Status of Programs

Section 1115 - RIteCare: Submitted July 20, 1993; approved November 1, 1993; implemented August 1, 1994.

Detoxification services: Implemented July 1, 1996.

RICover: Design phase.

Medicaid Substance Abuse Services Remaining Fee-For-Service

Residential substance abuse treatment programs (e.g., services for adolescents age 13 to 17) court order substance abuse services in which the court order specifies a nonnetwork provider.

Medicaid Mental Health Services Remaining Fee-For-Service

Outpatient (e.g., individual, group, and family therapy; day treatment); inpatient (e.g., acute psychiatric inpatient hospitalization); crisis (e.g., emergency room visits for psychiatric emergencies, crisis intervention); Institution for Mental Diseases

(IMD) services for individuals under age 21; mental health rehabilitation (e.g., community psychiatric supportive treatment, multidisciplinary psychiatric treatment planning, mobile treatment team).

Medicaid Substance Abuse Services in Managed Care Plan

Section 1115 - RIteCare: Opiate treatment programs (e.g., methadone maintenance, outpatient methadone maintenance); residential substance abuse treatment programs (except for children age 13 to 17); outpatient (e.g., day treatment, partial hospitalization); collateral visits; medically necessary court-ordered services.

Medicaid Mental Health Services in Managed Care Plan

Section 1115 - RIteCare: Outpatient (e.g., day treatment, partial hospitalization); mental health residential (except for residential treatment for children ordered by the Department of Children, Youth, and Families (DCYF); collateral visits; medically necessary court-ordered services.

Non-Medicaid Substance Abuse Services in Managed Care Plan

Detoxification services: Subacute and ambulatory detoxification.

RICover: Not yet determined.

Non-Medicaid Mental Health Services in Managed Care Plan

Section 1115 - RIteCare: Early and periodic screening, diagnosis, and treatment (EPSDT) services.

Detoxification services: Not applicable.

RICover: Prevention will be an integral part of the overall program and interwoven through the other services.

Populations Covered Under Managed Behavioral Health

Section 1115 - RIteCare: Children and adults mandatory: AFDC/TANF, uninsured pregnant women and children up to age 18 up to 250 percent of Federal poverty level (FPL).

Detoxification services: Children and adults voluntary: Indigent, uninsured at or below 200 percent of FPL.

RICover: Voluntary children and adults: Clinical criteria are used to determine eligibility. Clinical criteria include having a diagnosable mental, behavioral, or emotional disorder, or having been appropriately classified as a "community support client" in the Rhode Island public mental health system prior to promulgation of the new project, and having a disorder that has resulted in functional impairment lasting 6 or more consecutive months substantially interfering with or limiting two or more major life activities.

State Managed Care Program Administration

Section 1115 - RIteCare: RIteCare is administered by the Department of Human Service's Office of Managed Care. The Department contracts with four private, for-profit health maintenance organization (HMOs), which are paid on a capitated basis. The Department of Health provides consultation on the program evaluation component of the program. Three HMOs subcontract out for mental health and substance abuse services to behavioral health managed care organizations. The HMOs are fully at risk for these services, subject to stop-loss provisions. The State Department of Human Services monitors mental health and substance abuse service provision as well as all other covered services.

Detoxification services: This program is managed by the Rhode Island Department of Health. The Department contracts with one provider to manage services. This firm is a not-for-profit corporation. The provider subcontracts certain components, including ambulatory methadone detoxification and residential adolescent detoxification, to other in-state, licensed treatment programs. The primary provider provides the residential detoxification services in two settings, one in Providence and one in North Kingstown.

RICover: The Department of Mental Health, Retardation, and Hospitals will begin the program by contracting with four community mental health centers (CMHCs) that will be at partial risk. The State is considering the possibility of contracting with an administrative services organization (ASO) to assist with state-level data collection, medical management, and quality assurance.

Financing of Plans

Section 1115 - RIteCare: The source of funds is Medicaid as well as Title XXI Children's Health Insurance Program (CHIP). The four HMOs participating in RIteCare are paid on a capitated, per enrollee, per month basis. The program includes cost-sharing requirements, either in the form of monthly premium payments or point of service copayments. Individuals whose income is below 185 percent of FPL are not required to cost-share. Individuals whose income is between 185 percent and 250 percent of FPL are required to choose either monthly premium payments or copayments at the time services are delivered as their method of cost-sharing. Pregnant women between 250 percent and 350 percent of FPL pay both a monthly premium of about $106 to $118 and a copayment. Capitation rates were originally based on historical Medicaid fee-for-service (FFS) data. Rates are risk-adjusted by age and gender for all covered services. Mental health and substance abuse services in excess of stop-loss provisions are paid to the HMOs through the Medicaid FFS system. Budget neutrality under RIteCare is based on constraining the growth in Medicaid expenditures that do not produce savings. Providers are paid by the HMOs for mental health and substance abuse services on an FFS basis.

Detoxification services: The source of funds is combined State general revenue dollars and block grant funds. The managed care provider is paid monthly one-twelfth of the total contract amount. The agency is expected to serve all eligible Rhode Islanders, either on-site or through subcontracts. The provider is at risk in that the annual payment is capped, regardless of the number of eligible clients seeking services throughout the year. Rates for ambulatory methadone detoxification and adolescent residential detoxification are negotiated between the provider and the subcontractors.

RICover: The State plans to fund the program with Medicaid, Federal block grants, and State general fund dollars. The providers will be at partial risk defined by narrow risk corridors.

Coordination Between Primary and Behavioral Health Care

Section 1115 - RIteCare: Members receive both physical and mental health services through their chosen health plan. Adults with SPMI and children with SED receive their physical health care through the health plan but receive their behavioral health care through Medicaid FFS (except for labs and prescriptions, which are in-plan-covered benefits). HMOs are required to coordinate members' physical and behavioral health needs.

Detoxification services: Not applicable.

RICover: The State anticipates that physical health care will be on an FFS basis with a special rate designed for practitioners who agree to provide services on-site at a RICover provider agency.

Consumer-Family Involvement

Section 1115 - RIteCare: The Department of Human Services has a consumer advisory council (CAC) that meets monthly to discuss issues related to service access under Medicaid managed care. There is a mental health and substance abuse subcommittee of the CAC. The CAC reviews materials prepared by the State to be distributed to members and has played a key role in the design of member-satisfaction surveys.

Detoxification services: Because the amount of time given to applicants to respond to the RFP was extremely short, no input from consumer or family members was sought. However, client-satisfaction surveys, which include opportunities to suggest changes in program design, are administered to all clients who access services.

RICover: RICover evolved from a conference, heavily attended by consumers, on new paradigms in mental health services. RICover's steering committee includes two consumer/family representatives. Additionally, the State is implementing a consumer advisory panel that will have its own paid, professional staff to assist in everything from design to ongoing monitoring.

Future Plans

Section 1115 - RIteCare: The State plans to submit an amended CHIP plan to the Health Care Financing Administration (HCFA) to cover the following groups under RIteCare: uninsured children up to age 19 up to 300 percent of FPL; uninsured parents/relative caregivers of children enrolled in RIteCare up to 250 percent of FPL; uninsured older siblings (ages 19–23) of children enrolled in RIteCare up to 250 percent of FPL; uninsured par-

ents of children in Medicaid FFS up to 250 percent of FPL; and uninsured foster parents up to 250 percent of FPL.

Detoxification services: The managed care entity has found that ambulatory detoxification services are often not effective for a highly dysfunctional, unstable population. The State is examining the effect of less use of ambulatory detoxification and more reliance on subacute services on the overall program budget.

RICover: The State will continue to work on its benefit design, CMHC readiness, and pricing methodologies in the near future and anticipates taking the first steps toward implementation in January 1999.

State Agency Administration

The State Medicaid agency is the Department of Human Services. The adult mental health authority is the Department of Mental Health, Mental Retardation, and Hospitals. The child mental health authority is DCYF. The substance abuse authority is the Division of Substance Abuse, within the Department of Health.

Welfare Reform

The State's TANF program became effective June 1, 1997. It denies benefits to anyone convicted of a crime involving the sale or distribution of drugs. It does not test recipients for drug use.

County

Not applicable.

Evaluation Findings

Section 1115 - RIteCare: The Department has recently completed a Behavioral Health Access Study, and a Behavioral Health Clinical Focused Study is in the analysis stage. As of March 31, 1998, the program has enrolled 75,856 clients, 6,070 of whom represent the uninsured pregnant women and children population; 62.3 percent of enrollees are female; 37.7 percent are male. Only 2.9 percent of those eligible to change Health Plans during open enrollment chose to do so during the most recent enrollment period. The Department has an extensive monitoring and research program in place.

RICover: Not applicable.

Other Quantitative Data

Not applicable.

SOUTH CAROLINA

OVERVIEW

Currently, South Carolina Medicaid contracts with health maintenance organizations (HMOs) to provide the full range of Medicaid-covered services, including mental health, substance abuse treatment, and intervention services. This coverage is reimbursed up to $1,000 per recipient per year by the HMO, then by Medicaid on a fee-for-service (FFS) basis. The medically necessary services cover treatment in acute and long-term psychiatric and substance abuse care inpatient and outpatient settings. The Medicaid HMO contracts do not cover mental health and substance abuse prevention. In the mental health HMO agreement, selected case management and children's services are not included. Instead, these services are reimbursed on an FFS basis by Medicaid. The substance abuse HMO agreement includes case management services for all clients. There is a pilot project in the development stage to privatize mental health services for youth.

A second managed care program implemented in selected areas of the State is the Physician Enhancement Program. Mental health and substance abuse services are excluded from coverage in this program and remain under an FFS reimbursement system for enrolled clients.

Managed Care Programs for Behavioral Health Services

MEDICAID WAIVERS

Not applicable.

MEDICAID VOLUNTARY

Voluntary HMO program - integrated: HMOs licensed by the South Carolina Department of Insurance (SCDOI) and headquartered in South Carolina provide physical health, which includes acute care mental health and substance abuse services up to a $1,000 maximum benefit per enrollee. This program was implemented under the State Plan option; therefore, a waiver was not required.

OTHER MANAGED CARE PROGRAMS

Child Welfare Privatization Initiative - mental health stand-alone: South Carolina was one of 12 states awarded a Robert Wood Johnson Foundation grant to set up a pilot project to develop a mental health managed care system for youth.

Prior authorization - substance abuse stand-alone: Medicaid program, a coordinated delivery system of prior authorization for reimbursement of Medicaid substance abuse services.

Geographic Location

Voluntary HMO program: Counties. Each HMO that contracts with the Department of Health and Human Services (DHHS) provides services to individuals enrolled in their service area as approved by SCDOI. As of June 1, 1998, 12 percent of the counties were enrolled. Less than 1 percent of the Medicaid population is enrolled in the program.

Child Welfare Privatization Initiative: One region initially (region not yet selected), with plans to go statewide.

Prior authorization: Statewide.

Status of Programs

Voluntary HMO program: Implemented August 1, 1996.

Child Welfare Privatization Initiative: Request for Questions (RFQ) released November 1997 and still under review.

Prior authorization: Implemented July 1, 1997.

Medicaid Substance Abuse Services Remaining Fee-For-Service

Medicaid substance abuse treatment services include inpatient and outpatient (e.g., assessment,

physical examination, detoxification, case management, crisis management, individual/group counseling, day treatment, intensive in-home service, and therapeutic child care.)

South Carolina Department of Alcohol and Other Drug Abuse Service (DAODAS) has adopted the American Society of Addiction Medicine, Patient Placement Criteria-2 (ASAM-PPC2) as the standard for patient placement using their levels of care and definitions.

Medicaid Mental Health Services Remaining Fee-For-Service

Inpatient (e.g., psychiatric hospitalization); outpatient (e.g., psychiatrist services); residential (e.g., treatment facilities); mental health support (e.g., targeted case management); rehabilitation.

Medicaid Substance Abuse Services in Managed Care Plan

Voluntary HMO program: Substance abuse services include inpatient; outpatient (e.g., early intervention, psychological testing, medical assessment, assessment counseling); residential (e.g., intensive in-home services, high and moderate management group home services); acute; subacute; ambulatory detoxification.

Prior authorization: Inpatient and outpatient (e.g., assessment, physical examination, detoxification, case management, crisis management, individual/group counseling, day treatment, intensive in-home service, and therapeutic child care).

Medicaid Mental Health Services in Managed Care Plan

Voluntary HMO program: Mental health services include inpatient, outpatient, mental health support, rehabilitation, residential, and crisis.

Prior authorization: None.

Non-Medicaid Substance Abuse Services in Managed Care Plan

Child Welfare Privatization Initiative: Substance abuse services to be provided under this program have not been determined at this time.

Non-Medicaid Mental Health Services in Managed Care Plan

Child Welfare Privatization Initiative: Mental health services to be provided under this program have not been determined at this time.

Substance Abuse Prevention and Mental Health Promotion in Managed Care Plan

Voluntary HMO program: All prevention services available on a FFS basis are included in HMO rate (e.g., adult physical).

Child Welfare Privatization Initiative: Prevention services to be provided under this program have not been determined at this time.

Prior authorization: None.

Populations Covered Under Managed Behavioral Health

Voluntary HMO program: Adults and children voluntary: Aid to Families with Dependent Children/Temporary Assistance for Needy Families (AFDC/TANF); Supplemental Security Income (SSI); SOBRA.

Child Welfare Privatization Initiative: The population to be served by this program is children in foster care.

Prior authorization: Adults and children mandatory: AFDC/TANF.

State Managed Care Program Administration

Voluntary HMO program: As of June 1, 1998, Medicaid contracts with three private, for-profit HMOs to provide services. One HMO contracts with a behavioral health organization (BHO), the other two contract with the State mental health authority (South Carolina Department of Mental Health). The BHO is a for-profit entity.

The Department of Mental Health (DMH) and DAODAS contract with HMOs to provide behavioral health services up to the $1,000 limit. After the $1,000 limit has been met by the HMOs, Medicaid reimburses providers on an FFS basis.

Any HMO that is licensed by the SCDOI as domestic and that contracts with the DHHS is eligible to participate. The DHHS (Medicaid) is responsible for monitoring the provision of services,

whether provided under the HMO contract (up to the $1,000 limit) or on an FFS basis (after the $1,000 limit has been met). The DMH and DAODAS are State authority providers for mental health and substance abuse services respectively. Both departments act as service providers under both the HMO and FFS options. HMO providers are responsible for ensuring the provision of mental health and substance abuse services through contractual arrangements with appropriate providers and payment for such services up to the $1,000 limit. HMOs are responsible for maintaining a contractual relationship with appropriate providers to ensure the provision of the core benefits available under the HMO program.

The HMOs are expected to develop and implement a process to identify Medicaid HMO program members whose mental health needs may require extensive, specialty, or preventive intervention. DMH State staff may be required to participate in necessary continuity-of-care activities with the HMO for these members, including case consultation and service linkage activities. Also, the HMO can make referrals to community mental health centers (CMHCs). Oversight of the FFS inpatient Medicaid funds is assigned to DMH.

Child Welfare Privatization Initiative: Under the pilot, the State will contract with one nonprofit managed care organization (MCO) for all child welfare services. The MCO will not be responsible for physical health services. Children covered under Medicaid will still receive some physical and mental health services from the State. The MCO will be required to ensure that care for children needing health and correctional services (not included in the pilot) is coordinated.

Prior authorization: The Managed Care Division of DAODAS administers this program. The process of prior authorization of services has statewide accessibility through the County Alcohol and Drug Abuse Commissions, through a toll-free number during normal business hours and a 24-hour on-call reviewer. Training in the use of ASAM and the process of performing utilization review was provided throughout the state and will be ongoing. The DAODAS Managed Care Division consists of a director and six staff persons to administer the program.

Financing of Plans

Voluntary HMO program: HMOs are licensed and headquartered in South Carolina and are paid a capitated rate, per member, per month, according to age, gender, and category of eligibility. Medicaid reimburses for behavioral health services up to $1,000. After that limit is reached, DMH and DAODAS reimburse on a FFS basis for mental health and substance abuse services provided, respectively, using State general funds. Placement of savings generated from the program is to be determined. HMOs are allowed to retain profits in accordance with Department of Inurance (DOI) requirements. HMOs are at full risk but must maintain reinsurance protection in accordance with DOI requirements.

Child Welfare Privatization Initiative: Under the pilot, there will be two bundled rates to finance the initiative: one includes Medicaid funds for behavioral health and targeted case management, the other includes Federal entitlement dollars (e.g., Title IV-E, B) and State matching funds for all other services. Because a nonprofit MCO must be used under the Title IV-E restrictions, the state will share the risk with the MCO. There will be dollar incentives, however, for the MCO to stay within its budget and improve front-end services.

Prior authorization: Medicaid dollars fund this program.

Coordination Between Primary and Behavioral Health Care

Voluntary HMO program: DHHS and DMH have a memorandum of agreement that created an online communication system network with DHHS's Medicaid Management Information System. This online system allows DMH staff to access DHHS's Medicaid files and match new clients with Medicaid clients to determine whether incoming clients are eligible for Medicaid benefits and are signed up to be in an HMO. DMH can determine, on a monthly basis, the total number of clients who qualify for Medicaid and are in an HMO plan.

The HMOs are required to develop and implement a process to identify Medicaid HMO members whose mental health needs may require extensive, specialty, or preventive intervention. The HMO must provide the coordination necessary

for the referral of Medicaid HMO Program members to specialty providers and to out-of-plan services that may be available through FFS Medicaid providers. The HMO's behavioral health provider (mental health and substance abuse services) is required to participate in the necessary continuity-of-care activities with the HMO for the Medicaid members, including case consultation and service linkage activities. The HMO is also responsible for ensuring that coordination exists between the Supplemental Food Program for Women, Infants, and Children (WIC) and its network provider.

Child Welfare Privatization Initiative: Physical and other types of child welfare services will be coordinated on an FFS basis.

Prior authorization: Not available.

Consumer-Family Involvement

Voluntary HMO program: DHHS held several public hearings that allowed public input and feedback on program policy and procedures for Medicaid delivery options. In addition, DHHS continues to work with state agency providers in the development, implementation, and monitoring of program policy to ensure that issues of special needs populations are addressed in program design.

Child Welfare Privatization Initiative: The steering committee and the agencies involved highly recommend consumer involvement and are exploring a process to include it.

Prior authorization: Not available.

Future Plans

Voluntary HMO program: Future plans are to continue refining policies and procedures.

Child Welfare Privatization Initiative: Will be implemented statewide by January 1999. Future discussions will address the inclusion of medically fragile children in foster care.

Prior authorization: None.

★ *New Program Under Development:* The South Carolina DMH is engaged in planning efforts to develop an organized system of care that will enable South Carolina's mental health system to meet the challenges of the health care reform movement. Planning is organized around three functional areas (quality, access, and cost) that form the basis for the Department's movement toward a system of care that will be viable in the behavioral health care market. Internally, DMH staff are involved in a number of activities aimed at developing a better organized system of care. These include offering staff training, examining current commitment laws, developing utilization protocols, and refining management information. Currently, DHHS and DMH are collaborating on the best means of managing public behavioral health care in South Carolina.

Elements of the organized system of care include

- Some form of captitated or bundled rate program in consonance with the South Carolina DHHS;
- Standardized utilization management protocols for community mental health services;
- Quality and outcome monitoring measures;
- Accrediting CMHCs with an outside accreditation agency such as the Joint Commission on Accreditation of Healthcare Organizations or the Commission on Accreditation of Rehabilitation Facilities; and
- A plan to re-allocate inpatient State funds to the community.

Consumers have been involved in all phases of policy development and are members of the steering committee for the organized system of care. The consumer affairs coordinator (CAC) for DMH and members of the following advocacy groups are on the committee: Alliance for the Mentally Ill, Mental Health Association, and Self-Help Association Regarding Emotions (SHARE). CACs have also been involved in developing the concept of the organized system of care. They serve as the key contacts for consumer involvement.

★ *New Program Under Development:* DMH will also explore the possibility of managing physical and behavioral health care for targeted populations such as individuals with serious mental illness. Thus far, a study of Medicaid recipients' mental health service use and the commitment to physical health care needs has been completed for a recent 6-month period. The data are currently being analyzed. The paced development of managed care in the state has lessened the movement toward managing physical and behavioral health care for targeted populations, but has not eliminated the interest in managing the

health care of the most seriously and persistently mental ill.

State Agency Administration

South Carolina's Medicaid, DMH, and DAODAS operate under three separate agency administrations. DHHS is the sole State authority for Medicaid services. DAODAS renders substance abuse treatment, and DMH provides both mental health and substance abuse treatment services.

Welfare Reform

- Clients identified by case managers as having a substance abuse problem are referred to DAODAS for evaluation and/or treatment. The referral becomes a part of the client's Individual Self-Sufficiency Plan, and failure to go to DAODAS after referral is cause for a full-family sanction. Once treatment is successfully completed, the client is subject to random drug testing by DAODAS to ensure he or she is alcohol or drug free. If the testing finds substance abuse, the client must return to DAODAS for further treatment; failure to do so results in full-family sanction. Furthermore, if an AFDC/TANF client commits a drug felony, TANF will be denied.
- South Carolina submitted a Welfare to Work (WtW) plan on December 11, 1997; it was approved on February 29, 1998. The Employment Security Commission is the administering State agency. Matching funds for this grant will come from the State. The intended use of the 15 percent of State funds includes: staff capacity building, transportation, child care, technology enhancement, and vocational rehabilitation (including substance abuse).

The remaining 85 percent of funds will be split 50/50 between poor individuals and TANF recipients. Performance goals of the plan include: placement in unsubsidized jobs, job retention, and increase in earnings.

WtW entities and TANF agencies will coordinate efforts through regional administrators who will develop a needs assessment of the TANF participant population. This assessment will form the basis of the WtW local plan and any requests for proposals. The WtW State plan will allow for the provision of mental health and substance abuse services, but it is the decision of the service delivery area to contract with providers in order to make these services available to clients.

County

Not applicable.

Evaluation Findings

Voluntary HMO program: A formal evaluation of the HMO program is pending for program enrollment experience to assess cost, access, and quality of care. However, the HMO program has an ongoing external quality review component that is designed to assess HMO providers' compliance with the HMO contract requirements for quality, access, and availability in the provision of core services.

Child Welfare Privatization Initiative: Under this pilot, the State plans to conduct ongoing evaluations using a comprehensive monitoring and benchmark system that is still in the early design stages. The State is also exploring possible alternatives for conducting a formal external evaluation. A preliminary discussion has been made with an external entity to evaluate the program.

DMH received funds from the Center for Mental Health Services to take part in a study to determine the feasibility of measuring performance indicators. South Carolina, along with four other States, will work during fiscal year 98 to form a common set of performance indicators and to test whether these indicators can be measured.

The feasibility study has been completed and the final report sent to SAMHSA and the Center for Mental Health Services. The indicators were defined and are in the final report. The data from the report are being re-analyzed by each state. The 28 measures include clinical outcomes, consumer evaluation of care, consumer status, community services, and state hospital data. South Carolina was able to report 21 of the 28 measures. Several of the remaining data elements are under development.

Other Quantitative Data

Not applicable.

SOUTH DAKOTA

OVERVIEW

South Dakota operates a statewide primary care case management (PCCM) program under a 1915(b) waiver, as well as a capitation program for mental health services for adults with severe and persistent mental illness (SPMI). Under the PCCM, referral is required for mental health and substance abuse services except for specialty mental health services for children with severe emotional disturbances (SEDs) and adults with SPMI. Under the Division of Mental Health's capitation program, payments are capped for SPMI and SED clients.

Substance abuse services, funded by State general revenue funds, are not included in the capitation program. The Division of Alcohol and Drug Abuse, as the single State agency, provides case management for inpatient and outpatient clients.

Managed Care Programs for Behavioral Health Services

MEDICAID WAIVERS

Section 1915(b) - South Dakota Provider and Recipient in Medicaid Efficiency (PRIME) case management program - PCCM model integrated: Mental health services are included in managed care, except for recipients diagnosed with SED or SPMI. Substance abuse services are included for adolescents under age 21 and pregnant women.

MEDICAID VOLUNTARY

Not applicable.

OTHER MANAGED CARE PROGRAMS

CARE program - mental health stand-alone: Capitation program.

Geographic Location

Section 1915(b) - PRIME: Statewide.

CARE program: Statewide.

Status of Programs

Section 1915(b) - PRIME: Originally submitted: unknown; approved: unknown; implemented July 1, 1993. Renewal waiver submitted July 1, 1995.

CARE program: Implemented July 1, 1997.

Medicaid Substance Abuse Services Remaining Fee-For-Service

Inpatient and outpatient services are available for adolescents under age 21 and pregnant women.

Medicaid Mental Health Services Remaining Fee-For-Service

Inpatient; outpatient; Institution for Mental Diseases services for individuals 65 and over; mental health rehabilitation (e.g., targeted case management).

Medicaid Substance Abuse Services in Managed Care Plan

Section 1915(b) - PRIME: Inpatient, outpatient.

Medicaid Mental Health Services in Managed Care Plan

Section 1915(b) - PRIME: Referrals required for inpatient and outpatient.

S

Non-Medicaid Substance Abuse Services in Managed Care Plan

CARE program: Not applicable.

Non-Medicaid Mental Health Services in Managed Care Plan

CARE program: Services available for SPMI adults include mental health residential, mental health rehabilitation (e.g., Programs of Assertive Community Treatment (PACT), and Continuous Assistance, Rehabilitation, and Education (CARE)). Services available for children with SED include mental health support (e.g., in-home services, case management, liaison); crisis (e.g., individual, group, crisis intervention); outpatient (e.g., collateral contacts, assessment and evaluation, and psychological evaluation).

Substance Abuse Prevention and Mental Health Promotion in Managed Care Plan

Section 1915(b) - PRIME: Early and periodic screening, diagnosis, and treatment services.

CARE program: Not applicable.

Populations Covered Under Managed Behavioral Health

Section 1915(b) - PRIME: Children and adults mandatory: Aid to Families with Dependent Children/Temporary Assistance for Needy Families (AFDC/TANF), Supplemental Security Income (SSI), and low-income pregnant women; low-income children (State Children's Health Insurance Program).

CARE program: Adults voluntary: SPMI (defined according to State functional and diagnostic criteria).

State Managed Care Program Administration

Section 1915(b) - PRIME: The Medicaid agency pays primary care providers a fee for referral services.

CARE program: The Division of Mental Health pays providers a capitated rate for units of care. A unit of service is 15 minutes of contact with a provider. A maximum number of units is specified in each provider contract, with the stipulation that services must be provided to eligible recipients in the provider's designated catchment area throughout the duration of the contract period. Providers submit claims for billable units on a monthly basis. The claims are paid up to the maximum amount prior to the end of the contract period. The maximum amount varies by provider. Some providers may reach their maximum amount prior to the end of the contract period, while others may not fully access the maximum amount.

Financing of Plans

Section 1915(b) - PRIME: Medicaid and State dollars from the general fund finance this program.

CARE program: Medicaid and State dollars from the general fund finance this program. Providers are paid $55 per day for SPMI consumers and $62 per hour for SED children's services. The fee was established by the Director of Mental Health through negotiations with the executive directors of the mental health centers.

Coordination Between Primary and Behavioral Health Care

Section 1915(b) - PRIME: Primary care physicians assist clients in gaining access to the health care system and monitor on an ongoing basis the client's condition, health care needs, and service delivery.

The primary care physician is responsible for locating, coordinating, and monitoring all primary care and other medical and rehabilitation services on behalf of recipients enrolled in the waiver program.

CARE program: Not applicable.

Consumer-Family Involvement

Section 1915(b) - PRIME: Unknown.

CARE program: Families and consumers serve as members of the State Mental Health Planning and Advisory Council, which assists the Division of Mental Health in development of the State plan. Consumer advisory groups will be encouraged to become more active.

Future Plans

Section 1915(b) - PRIME: Unknown.

CARE program: The State plans to roll-in substance abuse services.

State Agency Administration

The State's Medicaid authority is the Office of Medical Services, within the Department of Social Services. The mental health authority is the Division of Mental Health and the substance abuse authority is the Division of Alcohol and Drug Abuse, both within the Department of Human Services.

Welfare Reform

State plan under P.L. 104-193 was filed with the U.S. Department of Health and Human Services on October 1, 1996, and became effective December 1, 1996. The program denies benefits to drug felons but does not test recipients for drug use.

The State's Welfare-to-Work plan includes mental health and substance abuse provisions.

County

Not applicable.

Evaluation Findings

The Division of Mental Health has received a grant to perform outcome surveys of mental health clients and their family members. Areas being examined are quality of life satisfaction, access to services, quality of services, and culturally competent services.

Other Quantitative Data

Not applicable.

TENNESSEE

OVERVIEW

Tennessee's managed behavioral health care program has gone through several iterations and continues to make adjustments in design, organization, and financing. Currently, behavioral health services are carved out and provided under a separate program known as TennCare Partners. Two private behavorial health organization (BHOs) are responsible for managing the program. Nine private managed care organizations (MCOs) provide physical health services under TennCare.

The behavioral health program has come under recent criticism for failing to provide needed services to patients with serious mental illness (SMI) and for contributing to the near deterioration of the traditional "safety net" mental health system. A series of improvements to correct problems identified in the program are being implemented:

1. The State distributed $7.75 million to community mental health agencies facing financial crisis;
2. The State has taken over management of the behavioral health pharmacy program and assumed financial responsibility for the cost of four antipsychotic and three generic drugs; and
3. The State Health Commissioner announced a proposed redesign of TennCare Partners that would, among other things, eliminate the program's priority population designation and give all enrollees access to the same benefit package, based on medical necessity.

A waiver amendment will be submitted to the Health Care Financing Administration (HCFA) to implement the provisions in the redesign (see Future Plans Section).

The State operates, separate from the TennCare program, a capitated mental health services program in correctional facilities.

Managed Care Programs for Behavioral Health Services

MEDICAID WAIVERS

Section 1115 - TennCare - carve-out: Covers general medical and behavioral health services on a capitated basis. Under an amendment, TennCare Partners carves out mental health and substance abuse services.

MEDICAID VOLUNTARY

Not applicable.

OTHER MANAGED CARE PROGRAMS

MHM Correctional Services, Inc. - mental health stand-alone: The Tennessee Department of Corrections (TDOC) contracted with a private, for-profit behavioral health managed care organization (BHMCO) to provide capitated mental health services to the Tennessee prison system.

Geographic Location

Section 1115 - TennCare and TennCare Partners: Statewide.

MHM Correctional Services, Inc.: Statewide.

Status of Programs

Section 1115 - TennCare: Submitted April 1993; approved November 18, 1993; implemented January 1, 1994. Amendment to Section 1115 waiver establishing TennCare Partners behavioral health carve-out submitted September 30, 1995, and approved April 4, 1996; implemented July 1, 1996.

MHM Correctional Services, Inc.: Contract awarded May 19, 1997; implemented July 1, 1997.

Medicaid Substance Abuse Services Remaining Fee-For-Service

Pharmacy.

Medicaid Mental Health Services Remaining Fee-For-Service

Pharmacy.

Medicaid Substance Abuse Services in Managed Care Plan

Section 1115 - TennCare Partners:

Nonpriority population: Inpatient and outpatient (limited to a lifetime benefit of $30,000 with 10 days detox coverage for the general TennCare population); crisis services; transportation.

Priority population: Additional unlimited services (inpatient, outpatient, transportation) provided to adults with SMI, children with severe emotional disturbance (SED), and children under early and periodic screening, diagnosis, and treatment (EPSDT).

Medicaid Mental Health Services in Managed Care Plan

Section 1115 - TennCare Partners:

Nonpriority population: Inpatient (e.g., psychiatric hospitalization for individuals between 22 and 64 years old; limited to 30 days per occasion, 60 days per enrollee); outpatient; crisis services; transportation.

Priority population: Additional unlimited services provided to adults with SMI, children with SED, and children under EPSDT: mental health support (e.g., case management, housing supports); rehabilitation (e.g., psychosocial); specialized outpatient services; residential (e.g., 24-hour care; housing).

Non-Medicaid Substance Abuse Services in Managed Care Plan

MHM Correctional Services, Inc.: Not applicable.

Non-Medicaid Mental Health Services in Managed Care Plan

MHM Correctional Services, Inc.: Outpatient (e.g., psychological testing, psychotherapy, evaluations, clinical supervision); pharmacy (management, drugs).

Substance Abuse Prevention and Mental Health Promotion in Managed Care Plan

Section 1115 - TennCare: EPSDT.

MHM Correctional Services, Inc.: None.

Populations Covered Under Managed Behavioral Health

Section 1115 - TennCare: Adults and children mandatory: Aid to Families with Dependent Children/Temporary Assistance for Needy Families (AFDC/TANF) (up to 185 percent federal poverty level (FPL)), Supplemental Security Income; optional expansion for pregnant women and children; children up to age 19 and uninsured children below 200 percent FPL who have access to health insurance but can't afford it (Children's Health Insurance Program); uninsurables; uninsured children of any income level.

TennCare Partners: TennCare population who meet medical necessity criteria; State-only SMI or SED whose incomes do not exceed FPL (do not receive TennCare medical/surgical benefits).

MHM Correctional Services, Inc.: individuals within correctional system. Presenting clinical symptoms dictate the level of care and type of professional(s) required to meet the needs of the inmate/patient. Inmates/patients in need of mental health programmatic services must meet clinical and administrative admission criteria for both inpatient and outpatient care.

State Managed Care Program Administration

Section 1115 - TennCare: The Tennessee Department of Health (DOH) is responsible for the Tennessee Medicaid program and retains overall authority over the TennCare program. Within the DOH, the Bureau of TennCare contracts with the nine MCOs.

TennCare Partners: The Tennessee DOH has overall responsibility for the TennCare Partners Program. DOH contracts with two private, for-profit BHOs and is responsible for monitoring the BHOs to keep the program fiscally viable.

All the services offered under the program are provided by one of the two BHOs under contract with DOH. The BHOs are responsible for organizing and coordinating all the covered mental health and substance abuse services needed by their enrollees. Each BHO has developed a network of

providers including community mental health centers (CMHCs) as well as specialty providers (e.g., Regional Mental Health Institutes) who have traditionally provided mental health services. Five CMHCs recently affiliated and formed a nonprofit entity in the Nashville area. The provider networks are reviewed by the TennCare Bureau quarterly to ensure availability of services.

MHM Correctional Services, Inc.: The Tennessee Department of Corrections contracts with a private, for-profit BHMCO to place psychiatrists and psychologists in 22 prisons throughout the state.

The State is responsible for ensuring that the quality of service delivery is maintained at an acceptable level and that inmates/patients requiring care receive the appropriate level of care in a timely and efficient manner. The State assists in the coordination and monitoring of doctoral level service delivery (e.g., development of outcome measures, reviewing performance measures and staffing levels). The BHO is responsible for ensuring that all the clinical obligations outlined in the contract are provided for by qualified mental/medical health professionals. The BHO must have a provider network in place that promotes system-wide continuity of service delivery.

Financing of Plans

Section 1115 - TennCare: This program is funded by Medicaid, State, and local dollars.

In the early phases of TennCare implementation, a blended capitation rate was used, in which Federal, State, and local expenditures for indigent health care were pooled. However, in July 1997, the State revised its method of capitation (pooled Federal, State, and local expenditures for indigent health care) and "unblended" its single capitation rate into two rates, one for the priority population (SMI) and one for the nonpriority TennCare population. This method is based on a fixed budget model. The two separate rates include the cost of psychotropic medications. The methodology and assumptions for "unblending" the behavioral health capitation rate is outlined below:

- The State has fixed the total amount of expenditures available to the BHOs for the delivery of mental health and substance abuse treatment services and psychotropic medications to TennCare beneficiaries. This amount is approximately $325,750,000.
- Forensic services were removed from the BHO capitation rate, reducing total expenditures by $22 million.
- The capitation rate for the priority population was set by the State at $319.41 per member per month.
- The capitation rate for the nonpriority members of TennCare will fluctuate based on the number of eligible members and the amount of money left after deducting the priority population capitation from the budget amount referred to above.

In addition, the previous capitation rates were increased by 5 percent as of January 1, 1998. The BHOs are fully capitated and at risk. No risk corridors are in place to protect the BHOs. Providers are paid on a fee-for-service basis.

MHM Correctional Services, Inc.: The BHMCO receives a capitated rate and shares the risk with providers. The capitated rate for the TDOC inmate/patient population was established by the BHO. The State determined its financial tolerance level prior to bidding the contract. Therefore, the State was in a position to reject bids that exceeded the department's budgetary limits. Various historical and projected demographics were made available to all prospective bidders (e.g., general inmate population, diagnosed population, patients receiving psychiatric medications). There are no mandates as to how profits are to be spent. There is a risk corridor in place to protect the BHO. The capitated rate may be renegotiated if and when the TDOC inmate population significantly fluctuates from the original population projections that were submitted to the BHOs during the bidding process. The BHO is paid monthly for services rendered based upon the in-house population at the time of billing.

Coordination Between Primary and Behavioral Health Care

Section 1115 - TennCare: The intent of folding TennCare Partners back into TennCare is that it will be easier and less confusing for people to get the health care they need from one responsible organization. It is important for enrollees, providers, and the State to have a single point of accountability.

MHM Correctional Services, Inc.: The BHO has a chief psychiatrist and mental health program director who coordinate the delivery of psychiatric and psychological services. The TDOC Director of Mental Health consults with the chief psychiatrist or program director routinely to ensure that all services are being provided in an acceptable manner. Clinical data are collected and reviewed by all pertinent professionals. Furthermore, the TDOC still has in place, at every facility, a State-employed mental health professional who assists in the coordination of services at their facility. The BHO's mental health program director coordinates monthly meetings with his or her doctoral level staff; issues such as service continuity, clinical supervision, and medication management are discussed.

Consumer-Family Involvement

Section 1115 - TennCare: Consumers were integrally involved in the development of the TennCare Partners Program waiver. Consumers are providing input to the State on the proposed fold-in of the Partners Program into the TennCare program.

MHM Correctional Services, Inc.: Clinical consumer demographics were taken into consideration when designing this program. Family members were not involved.

Future Plans

Section 1115 - TennCare: A waiver amendment will be submitted to HCFA for the following program improvements:

1. Eliminate the program's priority population designations, giving all TennCare members access to the same benefit package, based on medical necessity;
2. Broaden substance abuse treatment benefits;
3. Impose a new set of financial penalties for inadequate performance on the two BHOs;
4. Require each BHO to set aside $2.2 million per year for housing services, without financial risk beyond that amount;
5. Revise case management requirements to allow the level of case management to be determined on an individual basis; and
6. Hire a program director for TennCare Partners and create three staff positions responsible for services covering children, persons with substance abuse problems, and individuals with disabilities.

Additionally, the State has agreed to increase the global funding for behavioral health services if TennCare enrollment exceeds 1.225 million people.

MHM Correctional Services, Inc.: The TDOC is currently exploring the potential benefits of bidding out a comprehensive statewide health services contract that would include medical, mental health, and substance abuse services. Substance abuse services are currently contracted for a significant portion of the TDOC.

★ *New Program Under Development:* The State intends to commit $5.8 million over the next 5 years to develop a program for children and adolescents with SED through a Robert Wood Johnson proposal.

State Agency Administration

The Medicaid and Substance Abuse agencies are both under the DOH. Medicaid is within the Bureau of TennCare. Substance Abuse is within the Bureau of Alcohol and Drug Abuse Services. Mental Health is contained within its own department, the Department of Mental Health and Mental Retardation.

Welfare Reform

- Tennessee's Welfare to Work (WtW) grant was submitted to the U.S. Department of Labor on December 10, 1997, and is still pending approval. The plan will be administered by the Department of Human Services. Matching funds will come 100 percent from the State. The intended use of the 15 percent State project funds is incentive funding for private industry councils. The substate allocation formula for 85 percent of the funds will be split: 50 percent to the poor, 37.5 percent to TANF recipients, and 12.5 percent to the unemployed. The coordination between local WtW entities and local TANF agencies is already in place under the State's welfare reform program, Families First. Performance goals will be determined in the first 6 months of the program but will include job retention targeting long-term welfare recipients and noncustodial parents and increased wages.
- Under the State's TANF plan, drug testing is not mandatory for TANF recipients; however, if a

TANF recipient is convicted of a drug felony, he or she will be denied benefits.

County

Not applicable.

Evaluation Findings

1. *Section 1115 - TennCare:* Many external and internal evaluations have been conducted on TennCare. A few are highlighted below:
    - External review reports show that "patients who are denied care are not given the reason for refusal, not told of their right to appeal, and not given information about how to appeal—all of which are required by a Federal court order."
    - In a June 1997 report to HCFA, the State shared results from a survey it had conducted showing that community mental health services had declined by 12 to 15 percent during the first 6 months of the TennCare Partners Program.
2. A study commissioned by the Tennessee Association of Mental Health Organizations found the following:

- The monthly behavioral capitation rate for the priority population is $319.41.
    - The monthly behavioral health capitation rate for the nonpriority population, which will vary depending upon remaining funds, is estimated at $10.35.
    - An estimated 34 percent of the capitation rate for priority population is likely to be spent on medication.
    - An estimated 57 percent of the nonpriority population capitation is likely to be spent on medication.

3. A study conducted by University of Memphis and University of Tennessee, published in the March 18, 1998, *Journal of the American Medical Association* found that many patients lost access to care or lost continuity of care under the program. More specifically, researchers found the program spread funds previously earmarked for SMI patients across the entire Medicaid population. Many of the financially strapped centers stopped accepting new patients, discharged employees, or sought a buyout from for-profit managed care firms. Also, TennCare Partners adds a layer of administration—the BHOs—between the State and the intended beneficiaries. This addition increases the structural complexity of the delivery system and reduces the resources available for patient care. The creation of BHOs as separate behavioral health entities parallel to the general TennCare MCOs makes it difficult for both the State and consumers to identify the accountable party.

Other Quantitative Data

Section 1115-TennCare: Enrollment is up to 1.265 million as of July 1998, from 1.07 million in March 1998.

TEXAS

OVERVIEW

A new behavioral health stand-alone program in the Dallas area, to be implemented in 1999, will combine all mental health and substance abuse funding to serve Medicaid clients and the indigent. This model differs from other models being implemented in the State, which involve nonspecialty health maintenance organizations (HMOs) that subcontract for management of behavioral health services.

Texas' Medicaid managed care program, known as State of Texas Access Reform or STAR, has historically encompassed three models: A full-risk HMO model, a partial-risk prepaid health plan, and a no-risk enhanced primary care case management (PCCM) model. These models, targeted primarily to individuals with acute care needs, have been implemented in six regions of the State. Under these models, acute, outpatient, and inpatient behavioral health care are provided and HMOs have some flexibility to offer nontraditional services within their capitation rate. Medicaid clients with serious mental illness (SMI) receive Medicaid Rehabilitation and Targeted Case Management through the Texas Department of Mental Health and Mental Retardation (TDMHMR).

The new stand-alone model will be implemented on a pilot basis in 1999, with the newest roll-out of Medicaid managed care in the Dallas region. Using Medicaid, all State mental health funds, most chemical dependency State and federal funds, State general revenue, federal block grant funds, and local funds, the State plans to create a more seamless system of public behavioral health care for persons with acute, intermediate, and long-term care needs. Under this roll-out, known as NorthSTAR, mental health and substance dependency benefits will be carved out from STAR (the physical health plan) and managed by behavioral managed care organizations on a full-risk capitated basis. Contractors will be required to subcontract with specialty provider networks (SPNs) for the treatment of individuals with SMI and severe emotional disturbance (SED). The SPNs include traditional provider organizations that have historically delivered these specialized services in the NorthSTAR region. Chemical dependency/abuse benefits will include traditional Medicaid services and social medical or social model programs previously funded by non-Medicaid sources.

Managed Care Programs for Behavioral Health Services

MEDICAID WAIVERS

Section 1915(b) - STAR Health Plan - integrated: Provides inpatient, outpatient, and value-added mental health services using HMO and PCCM models.
Section 1915(b) - NorthSTAR: Behavioral health stand-alone: provides mental health and substance abuse services on a capitated basis.

MEDICAID VOLUNTARY

Not applicable.

OTHER MANAGED CARE PROGRAMS

Section 1915(b): NorthSTAR - Behavioral health stand-alone: provides mental health and substance abuse services to Medicaid recipients and to medical indigents who are not in long-term care institutions and who meet specific clinical criteria (e.g., SED, severe and persistent mental illness). Services to Medicaid eligibles will be provided under 1915(b) waiver authority.

OTHER MANAGED CARE PROGRAMS (CONTINUED)

Texas Integrated Funding Initiative: Mental health stand-alone: the State is piloting the pooling of public funds spent among State and local agencies on children with SED and substance abuse/dependency problems. A 501(c)(3) organization will manage care and use of pooled funds. The projects are very close to implementation.

Geographic Location

Section 1915(b) - STAR Health Plan: Following counties and contiguous areas: Travis, Bexar, Lubbock, Tarrant, Jefferson, Galveston, Chambers, and Harris; STARPlus in Harris and Houston counties. In fiscal year 1998, this area constituted 19.48 percent of Medicaid eligibles.

Section 1915(b) - NorthSTAR: Dallas (urban), Collin (suburban), Hunt (rural), Ellis (suburban), Navarro (rural), Rockwall (suburban), and Kaufman (suburban) counties. This area constitutes approximately 91 percent of Medicaid eligibles.

Texas Integrated Funding Initiative: Three Mental Health Authority catchment area/counties. One is an urban area (one county), one a suburban area (four counties), and one a rural area (two counties).

Status of Programs

Section 1915(b) - STAR Health Plan: Implemented in Travis County and Southeast Region August 1, 1993. Bexar County and contiguous areas: submitted on May 28, 1996; approved on August 30, 1996; implemented on September 1, 1996. Lubbock County: submitted on June 21, 1996; approved September 20, 1996; and implemented October 1, 1996. Tarrant County: submitted June 20, 1996; approved September 18, 1996; implemented on October 1, 1996. Harris County: submitted June 1997; and approved on October 10, 1997. Brazoria, Fort Bend, Montgomery, and Waller (these counties are the Harris county contiguous areas) counties: implemented on March 1, 1998.

Section 1915(b) - NorthSTAR: Comments on Request for Applications (RFAs) due May 18, 1998; RFA to be released June 25, 1998; applicant response due September 11, 1998; managed care organizations (MCOs) named November 1, 1998; contracts signed February 1, 1999; waiver to Health Care Financing Administration, March 1, 1999; implementation July 1, 1999.

Texas Integrated Funding Initiative: Two sites are implementing; one is still in planning stages. Two additional sites (both urban) are also in planning stages.

Medicaid Substance Abuse Services Remaining Fee-For-Service

The following substance abuse services for adults remain in the fee-for-service system: outpatient and individual counseling (e.g., general acute hospital).

Medicaid Mental Health Services Remaining Fee-For-Service

The following mental health services are covered under Texas' Medicaid program: inpatient (e.g., hospital (30-day limit per spell of illness for adults, no limit for children), psychiatric services for individuals under age 21, and age 65 and older (no limit)); outpatient (e.g., psychiatrists' services: 30 encounters per calendar year, treatment beyond initial 30 encounters requires written prior authorization, nonphysician services (licensed psychologists, licensed master social workers-advanced clinical practitioners (LMSW-ACPs) and licensed professional counselors (LPCs) 30 encounters per calendar year, treatment beyond initial 30 encounters requires written prior authorization); rehabilitation; support (e.g., targeted case management); pharmacy (e.g., limited to three per month per client unless client is enrolled in Medicaid managed care).

Medicaid Substance Abuse Services in Managed Care Plan

Section 1915(b) - STAR Health Plan:

For members under age 21: inpatient; outpatient; value-added services (e.g., day treatment; partial hospitalization; counseling, limited to 30 per calendar year unless medically necessary and prior authorized).

For members over age 21: outpatient; inpatient.

Section 1915(b): NorthSTAR: inpatient detoxification; outpatient; inpatient; residential; rehabilitation; services for dually diagnosed.

Medicaid Mental Health Services in Managed Care Plan

Section 1915(b) - STAR Health Plan: Inpatient; outpatient; value-added.

Section 1915(b) - NorthSTAR: Outpatient (e.g., screening, assessment, counseling, psychiatrist, psychologist); pharmacy; emergency transportation; inpatient; rehabilitation.

Outpatient counseling is limited to 30 visits unless additional visits are medically necessary and prior authorized for individuals over age 21. HMOs may also provide social model flex benefits such as 24-hour residential programs and other specialized services for people in clinical need of these services.

Non-Medicaid Substance Abuse Services in Managed Care Plan

Section 1915(b) - NorthSTAR: Inpatient detoxification; outpatient; inpatient; residential; rehabilitation; services for dually diagnosed.

Texas Integrated Funding Initiative: Not applicable.

Non-Medicaid Mental Health Services in Managed Care Plan

Section 1915(b) - NorthSTAR: Outpatient (e.g., screening, assessment, counseling, psychiatrist, psychologist); pharmacy; emergency transportation; inpatient; rehabilitation.

Texas Integrated Funding Initiative: A wraparound approach is being implemented to provide flexibility for both formal and informal services. Examples include mentoring, tutoring, recreating, and school behavioral specialists.

Substance Abuse Prevention and Mental Health Promotion in Managed Care Plan

Section 1915(b) - STAR Health Plan: Early and periodic screening, diagnosis, and treatment (EPSDT).

Section 1915(b) - NorthSTAR: Life skills training, all-stars program, promoting alternative thinking strategies, preparing for drug-free years, strengthening families program for youth age 10 to 14 or equivalent models, funding HIV early intervention and outreach programs, infant intervention programs for mothers, and reconnecting youth programs for indicated populations.

Texas Integrated Funding Initiative: The target population is children with more severe problems who tend to have higher service utilization and costs. The prevention is working toward keeping children in their communities, so they don't end up in residential care.

Populations Covered Under Managed Behavioral Health

Section 1915(b) - STAR Health Plan: Adults and children mandatory: Aid to Families with Dependent Children/Temporary Assistance for Needy Families (AFDC/TANF); optional expansion pregnant women and children (up to 185 percent Federal poverty level (FPL)). Voluntary: Supplemental Security Income (SSI).

Section 1915(b) - NorthSTAR: Adults and children mandatory: AFDC/TANF; optional expansion pregnant women and children (below 185 percent FPL); SSI; medically indigent (above 185 percent FPL). Individuals above 185 percent FPL are responsible for copays based on a sliding scale basis.

Texas Integrated Funding Initiative: Voluntary: Any child is eligible based on availability and clinical need.

State Managed Care Program Administration

Section 1915(b) - STAR Health Plan: The Texas Department of Health (TDH) contracts with for-profit and nonprofit HMOs and serves as a contract monitor and regulator. The HMOs' role is to provide medically necessary services to the covered lives and meet required outcomes for their care. The State mental health authority's (TDMHMR's) role is to provide leadership in behavioral health policy, clinical, and program matters. TDMHMR is also statutorily required to develop standards for behavioral health in Medicaid managed care initiatives.

All of the current HMO plans subcontract behavioral health to private, for-profit behavioral health managed care organizations (BHMCOs). BHMCOs contract directly with providers and community mental health centers to provide treatment. Long-term mental health services are available and authorized through the local public mental health authorities, using Medicaid Rehabilitation

and Targeted Case Management funds, as well as other State, local, and Federal revenue.

Section 1915(b) - NorthSTAR: TDMHMR and the Texas Commission on Alcohol and Drug Abuse (TCADA) intend to contract on a competitive basis with two MCOs. These MCOs can be HMOs or limited purpose HMOs. Limited purpose HMOs are HMOs that provide specialty services (e.g., behavioral health). A new licensure category allows community nonprofit providers to accept risk.

These organizations will be responsible for network development and management, utilization review, quality management, and data management and analysis. MCOs (NorthSTAR plans) can be providers in their own networks but cannot be a local behavioral health authority (LBHA). The NorthSTAR Plans, in turn, will contract with a specialty network to provide specialized services to SMI and SED clients. Specialty substance abuse services will be provided or monitored by an organized network under contract from the MCO.

The program will establish a single LBHA for the seven-county region, eliminating the dual role currently played by the area's five community mental health centers as providers and local authorities. Those centers will continue to have a role in the new program, with first right of refusal for creating the specialty network for adults and children. The LBHA will be a newly constituted independent entity created for mental health and substance abuse purposes. Current mental health authorities will no longer be the designation for Community Mental Health and Mental Retardation Centers but rather the designation for autonomous entities in the service region. Local entities that provide the match for State mental health funds (largely county governments) in the seven counties would form the LBHA. TDMHMR and TCADA would contract with the LBHA to perform planning and oversight activities on behalf of the state and community. The LBHA cannot be an MCO or a provider in the MCO's network.

Texas Integrated Funding Initiative: An administrative services organization (ASO) contracts with "any willing provider." The ASO is responsible to the funders for outcomes (funders can include mental health, juvenile justice, child welfare, substance abuse, education departments).

Financing of Plans

Section 1915(b) - STAR Health Plan: Medicaid, State, and Federal dollars finance this program. The TDH contracts with HMOs on a capitated basis and shares profits on a 50/50 basis. No stop-loss or reinsurance mechanisms are in place. This was developed to prevent excessive profit incentives to the plans.

The HMO capitation rate for behavioral health is blended into the capitated rate for physical health. Differential rates are established for client groups depending on risk. There are separate benefit packages for persons under age 21 and for persons age 21 and over. The State developed a maximum capitation rate for each county and for each population category/risk group. Using fee-for-service data, State actuaries determined per-member per-month (PMPM) expenditures for each group with adjustments. Rates were discounted to reflect anticipated savings.

The range of risk passed on to subcontractors ranges from full to none (e.g., paid on a fee-for-service basis). Subcontractors are generally paid capitated rates when at risk. Some subcontractors are paid on a fee-for-service basis.

Section 1915(b) - NorthSTAR: Under the pilot, State general revenue dollars, Federal mental health block grant funds, and Medicaid dollars will be blended to fund the $93 million program. Local funders who choose to participate with the LBHA will contribute their required local mental health match and may designate how those match dollars are to be used. The TCADA treatment dollars are included.

At least two MCOs will bear full risk for providing services to eligible populations. MCOs will be paid on a capitated basis while specialty care may be financed on a case rate or other reimbursement basis. Under the carve-out, the specialty network contract will include federal Projects for Assistance in Transition from Homelessness (PATH) funds for outreach to homeless mentally ill. Specialty provider networks will negotiate the payment method.

Capitation rates will be on a PMPM basis and calculated for identified population categories. State hospital bed usage has been included in the premium at its cash equivalent, and the MCOs will have the option of taking 5 percent of that amount and applying it to other services. Any direct service funds not used in achieving penetration rate targets

or not expended to achieve the direct services funding requirements will be reinvested the following year. Contractors will collaborate with the LBHA and the State to develop strategies to direct savings toward identified service priorities.

Texas Integrated Funding Initiative: Funding streams can include child welfare, IV-E and IV-B funds, general revenue, city and county funds, noneducation funds, and Federal grants. Funds are integrated through the ASO, by contracts, and paid by the ASO. A case rate reimbursement is utilized at this time.

Coordination Between Primary and Behavioral Health Care

Section 1915(b) - STAR Health Plan: Care is considered under this program through the following requirements:

- Quality assurance systems must integrate behavioral health.
- Primary care providers and behavioral health specialists are required to share clinical information (with patient permission). Medical record review examines this parameter.
- Focused studies examine physical/behavioral interface.
- Local advisory committees integrate behavioral health perspective into STAR advisory committee.

Section 1915(b) - NorthSTAR: The TDH will operate the Medicaid physical health care program in the Dallas service region through separate contracts with MCOs. It is the State agencies' intent to continue the coordination of physical and behavioral health care delivery in the Dallas pilot. Current contractual requirements for provider communication and coordination, provider training, and medical record integration will be improved. TDH, TDMHMR, and TCADA will jointly monitor MCO performance in this area.

Texas Integrated Funding Initiative: No efforts are in place at this time to coordinate physical and behavioral health care under this program.

Consumer-Family Involvement

Section 1915(b) - STAR Health Plan: Meetings with consumer and advocacy organizations and public hearings were held by the Health and Human Services Commission (HHSC) to solicit input into the 1915(b) waivers. Stakeholders do not have a formal role in implementation or oversight at the State level. On the service delivery level, HMOs must have representation of members receiving behavioral health services in their quality improvement processes.

There is strong consumer involvement within the local mental health authorities. Advisory planning committees must include at least 50 percent consumer representation.

Section 1915(b): NorthSTAR: The contractor will provide a variety of opportunities for consumers of public behavioral health services and their families to have meaningful involvement in the design, implementation, operation, and oversight of NorthSTAR. The contractor will coordinate such activities with the LBHA. The contractor will also work with consumers and families to identify and develop opportunities for meaningful involvement and to inform consumers and families about the opportunities that are available. A broad coalition of advocacy groups has been engaged in a patient education campaign since October 1997.

The contractor will provide opportunities for input from its provider network, community consortiums and advocacy groups, professional organizations, and representatives from local units of government (e.g., the court and criminal justice system, education, child protective services).

Texas Integrated Funding Initiative: Families contributed to the design of this waiver through focus groups, trainings, and planning meetings.

Future Plans

Section 1915(b) - STAR Health Plan: Statewide by 2001.

Section 1915(b) - NorthSTAR: See Status Section.

Texas Integrated Funding Initiative: Two additional sites are in planning stages. Two current sites are implementing the program.

★ *New Program Under Development:* The TCADA and the TMDHMR released a request for proposals on April 20, 1998, to solicit proposals from coalitions of mental health and substance abuse treatment providers to coordinate and adapt existing substance abuse and mental health services. Proposals are due September 1998. Contract will be awarded November 1998, and implementation is set to begin July 1999.

★ *New Program Under Development:* Texas will be implementing a child welfare demonstration in the Dallas/Fort Worth area. One primary contractor will be selected and responsible for delivering or subcontracting with other providers to deliver a continuum of placement, family reunification, and adoption services. The method of reimbursement has yet to be determined.

- Based on TCADA's Statewide Service Delivery Plan, certain steps will be taken in the near future:
  - ➢ Accept network applications for four regions, of which two regions will be accepted.
  - ➢ Incorporate managed care tools to transition to a system of network case management. These community-based networks in conjunction with local advisory groups such as the Regional Advisory Consortia will, over time, replace the current method of service delivery.
  - ➢ Change funding allocation formula: move from six separate allocation formulas to a single formula that contains specific factors.
  - ➢ Subdivide 11 service regions into 29 smaller subregions. TCADA's service system and funding allocation system will be designed around these subregions.
  - ➢ Carve out substance abuse treatment/prevention services to the Single State Authority (TCADA), which would then bid out services to public or private companies.

State Agency Administration

Medicaid, Mental Health, and Substance Abuse agencies are housed in three separate departments in Texas. The HHSC serves as the Medicaid agency. TDMHMR and TCADA are the mental health and substance abuse agencies, respectively.

Welfare Reform

- There are no initiatives in the State's welfare reform plan that specifically address public sector behavioral health care clients.
- A number of persons on SSI because of their drug or alcohol dependence will be dropped from the rolls. Texas is projected to receive an additional $3 million in Federal block grant funds to serve these people as a first priority. TDMHMR and the TCADA are working together to notify individuals of the availability of services with this funding. Currently, Texas does not require mandatory drug testing of TANF recipients; however, the State does deny TANF to those individuals convicted of drug felonies.

County

Not applicable.

Evaluation Findings

Section 1915(b) - STAR Health Plan: HMOs are mandated to conduct focused quality of care studies and are required to comply with Health Employer Data and Information Set (HEDIS) measures as well. Additionally, the Texas Health Quality Alliance is in the process of validating data submitted and conducting quality evaluation. Evaluation reports will be generated this fall.

Section 1915(b): NorthSTAR: Examples of potential evaluation activities include:

- Encounter data validation;
- Medical record review;
- Consumer satisfaction;
- Local advisory groups; and
- Analysis of complaints, prior authorization, and other access and quality issues.

Other Quantitative Data

Not applicable.

UTAH

OVERVIEW

Utah operates a public sector managed care program for mental health services under Medicaid. Substance abuse services remain in the fee-for-service system. Physical health services are provided through health maintenance organizations (HMOs) and primary care case management programs. The prepaid mental health plan (PMHP) was approved under a 1915(b) waiver effective July 1, 1991, which covers most of the State. The State has maintained the traditional mental health delivery system by contracting directly with community mental health centers (CMHCs) as managed care entities.

In June 1995, Utah submitted an 1115 health waiver request to expand Medicaid coverage to more low-income Utah residents and to simplify the eligibility process. The 1915(b) waiver for the PMHP will be subsumed into the 1115 waiver once it is approved, although mental health services will continue to be carved out in a separate program. New to the program will be a separate stand-alone plan for substance abuse services. The 1115 waiver, however, has not yet been approved and is on hold. For more information on this program, see the Future Plans Section.

Managed Care Programs for Behavioral Health Services

MEDICAID WAIVERS

Section 1915(b) - PMHP - mental health stand-alone: Covers mental health services only.

MEDICAID VOLUNTARY

Not applicable.

OTHER MANAGED CARE PROGRAMS

Not applicable.

Geographic Location

Section 1915(b) - PMHP: Implemented in 25 out of 29 counties. Not implemented in San Juan, Daggett, Duchesne, and Uintah Counties.

Status of Programs

Section 1915(b) - PMHP: Submitted in September 1988; approved in April 1990; implemented July 1, 1991.

Medicaid Substance Abuse Services Remaining Fee-For-Service

Outpatient; prescription drugs. These services are covered by fee-for-service in two small rural areas only.

Medicaid Mental Health Services Remaining Fee-For-Service

Inpatient; outpatient; mental health rehabilitation (e.g., targeted case management); prescription drugs.

Medicaid Substance Abuse Services in Managed Care Plan

Section 1915(b) - PMHP: Not applicable.

Medicaid Mental Health Services in Managed Care Plan

Section 1915(b) - PMHP: Inpatient; outpatient; mental health rehabilitation (e.g., targeted case management).

Non-Medicaid Substance Abuse Services in Managed Care Plan

Not applicable.

Non-Medicaid Mental Health Services in Managed Care Plan

Not applicable.

Substance Abuse Prevention and Mental Health Promotion in Managed Care Plan

Section 1915(b) - PMHP: PMHP contractors have the flexibility to provide prevention services appropriate to client need. Contractors provide a variety of psycho-educational groups, housing, and employment support services, for example.

Populations Covered Under Managed Behavioral Health

Section 1915(b) - PMHP: Children and adults mandatory: Aid to Families with Dependent Children/Temporary Assistance for Needy Families, Supplemental Security Income (e.g., aged, disabled), medically needy, pregnant women, and children.

State Managed Care Program Administration

Section 1915(b) - PMHP: The Division of Health Care Financing (DHCF) has sole-source contracts with eight CMHCs on a capitated basis for mental health services. The original three CMHCs in the program were selected through a competitive bidding process that included any entity that could provide either directly or through subcontract the inpatient and outpatient range of services to be covered. Five more CMHCs started contracts with the State on July 1, 1995. All PMHP contractors subcontract with hospitals for inpatient psychiatric services, and all of them subcontract to some degree with selected community providers to provide outpatient mental health services.

Financing of Plans

Section 1915(b) - PMHP: PMHP is financed through Medicaid dollars. The State pays the CMHCs directly. CMHCs are at risk for both inpatient and outpatient mental health services. The CMHCs are paid a premium based on Medicaid aid category for every Medicaid recipient in the county, regardless of whether they use mental health services. Under capitation, CMHCs are free to negotiate discounted inpatient rates with hospital providers. If CMHCs are able to decrease inpatient expenses by increasing outpatient services, they are allowed to keep the inpatient savings.

Coordination Between Primary and Behavioral Health Care

Section 1915(b) - PMHP: The PMHPs are required by contract to coordinate the provision of covered mental health services with the client's HMO and primary care physician. The contractors are also required to educate HMOs and primary care physicians on the diagnosis, treatment, and referral of behavioral health disorders commonly seen in primary care.

Consumer-Family Involvement

Section 1915(b) - PMHP: Representatives from the Utah Alliance for the Mentally Ill were involved in the reviewing the responses to the "Formal Solicitation for Participation in a Prepaid Mental Health Plan" received from the five new PMHP contractors. DHCF will also invite representatives from consumer groups to participate in on-site visits to the contractors during the next waiver renewal process. Since implementation, representatives from the Utah Alliance for the Mentally Ill were invited to review and provide input into Medicaid's Third PMHP Operating and Monitoring Plan and are invited to review and comment on the PMHP contracts as they are revised. Representatives from Allies for Families, a children's mental health advocacy group, have been invited on contractor site visits to discuss access to and quality of children's services. In addition, family members and consumers are invited to the contractors' annual public hearings to provide feedback regarding services. Consumers and families will have the same role regardless of whether services are provided under an 1115 or 1915(b) waiver.

Future Plans

Section 1915(b) - PMHP: The State will let this program expire if the 1115 waiver is approved. The

Medicaid agency is currently planning to add substance abuse services to the 1915(b) waiver effective January 1, 2000. PMHPs will receive separate premiums for substance abuse services.

Section 1115 - Demonstration: The State is awaiting approval of this waiver, which was submitted June 30, 1995. An implementation date of January 1, 2000, has been agreed upon by all parties. The waiver is intended to expand eligibility for services on a statewide basis. Mental health and substance abuse services would continue to be provided as a carve-out from physical health care services under the 1115 waiver as they are under the 1915(b) waiver. The PMHPs will be required by contract to coordinate the provision of covered mental health services with the client's HMO and primary care physician. The contractors will also be required to educate HMOs and primary care physicians on the diagnosis, treatment, and referral of behavioral health disorders commonly seen in primary care. During the next year, expenditure and utilization data will be gathered and analyzed to establish capitation rates.

State Agency Administration

The DHCF, within the Department of Health, is the State's Medicaid agency. The State's mental health (Division of Mental Health) and substance abuse authorities (Division of Substance Abuse) are in the Department of Human Services.

Welfare Reform

State plan under P.L. 104-193 was filed with the U.S. Department of Health and Human Services (DHHS) on September 30, 1996, and became effective September 30, 1996. The plan requires a person with a drug felony conviction to receive treatment and make progress as a condition for receiving cash assistance. Recipients are not tested for drug use.

Utah's welfare reform demonstration operates with a waiver under Title IV-A, Section 1115, of the Social Security Act. The demonstration, entitled Utah Single-Parent Employment Demonstration (SPED), was one of the first welfare reform demonstration projects to be approved by DHHS. The program imposes sanctions for failure to participate, requires children to attend school regularly, requires preschool children to receive immunizations unless the family has religious objections, defines a household to include all related persons in the household (and all their incomes are included in the case unit), provides case management, increases resource limits, simplifies income rules to require families to report only monthly income fluctuation that exceeds $100, and increases Job Opportunities and Basic Skills (JOBS) participation requirements and activities. The program's amendments were approved July 1996; it is authorized until December 31, 2000.

County

Not applicable.

Evaluation Findings

An independent assessment of the PMHP has been conducted that included an extensive evaluation of services and outcomes for beneficiaries with schizophrenia and an evaluation of cost effectiveness. Medicaid has also submitted two waiver renewals reporting on access, quality, and cost.

Other Quantitative Data

The three contractors submitted client-specific shadow claims data for the first 4 years. The data were used to determine outpatient penetration rates, average amounts of services received, number of recipients with inpatient stays, number of inpatient admissions, readmission rates, and average lengths of stay, for example. The State is currently collecting client-specific encounter data from all eight contractors to conduct similar utilization analyses. A follow-up study on outcomes for beneficiaries with schizophrenia is also being conducted by the Division of Mental Health.

VERMONT

OVERVIEW

Vermont operates one statewide integrated Medicaid managed care program, Vermont Health Access Plan (VHAP), for acute care services. Health maintenance organizations (HMOs) implement the program. Behavioral health services are subcontracted to two types of organizations: 1) a non-profit joint venture between community mental health centers and a behavioral health managed care organization (BHMCO) and 2) a single for-profit BHMCO.

For non-Medicaid mental health services, the Department of Developmental Disabilities and Mental Health Services (DDMHS) has begun a major restructuring effort that includes, among other managed care principles, a new case rate funding mechanism for people needing chronic mental health care services. This initiative is part of a system-wide restructuring effort for the public mental health system and will combine Medicaid and State mental health funds into a single service system.

Non-Medicaid substance abuse services continue to be administered by the State substance abuse authority under the traditional grant system.

Managed Care Programs for Behavioral Health Services

MEDICAID WAIVERS

Section 1115 - VHAP - integrated: Acute behavioral health services are integrated into the waiver. Long-term services to people with chronic mental health disorders are not included and remain under the State mental health authority's administration (see Future Plans Section).

MEDICAID VOLUNTARY

Not applicable.

OTHER MANAGED CARE PROGRAMS

DDMHS Restructuring - mental health stand-alone: Initiative to develop case rate funding mechanism for chronic mental health services.

Geographic Location

Section 1115 - VHAP: Statewide.

DDMHS Restructuring: Statewide.

Status of Programs

Section 1115 - VHAP: Submitted February 5, 1995; approved July 28, 1995; implemented January 1, 1996.

DDMHS Restructuring: Case rate financing: October 1998; management information system: September 1998; designation criteria: January 1999; new client eligibility criteria: January 1998; performance indications/outcomes: July 1999.

Medicaid Substance Abuse Services Remaining Fee-For-Service

Detoxification; residential; inpatient; and outpatient.

Medicaid Mental Health Services Remaining Fee-For-Service

Inpatient; outpatient; Institution for Mental Diseases (IMD) services.

Medicaid Substance Abuse Services in Managed Care Plan

Section 1115 - VHAP: Substance abuse services include inpatient; outpatient; detoxification; residential.

Medicaid Mental Health Services in Managed Care Plan

Section 1115 - VHAP: Mental health services include inpatient; outpatient; mental health support (e.g., group and individual treatment); pharmacy; rehabilitation; crisis; residential; IMD services (30 days per episode and 60 days per year).

DDMHS Restructuring: Not applicable.

Non-Medicaid Substance Abuse Services in Managed Care Plan

DDMHS Restructuring: Not applicable.

Non-Medicaid Mental Health Services in Managed Care Plan

DDMHS Restructuring: Not applicable.

Substance Abuse Prevention and Mental Health Promotion in Managed Care Plan

Section 1115 - VHAP: None.

DDMHS Restructuring: None.

The Department of Health collaborated with one major managed care organization (MCO) (same as under VHAP) that contracted with Medicaid to develop a training curriculum on substance abuse prevention. The training is made available on a voluntary basis to health care providers, doctors, nurses, etc.

Populations Covered Under Managed Behavioral Health

Section 1115 - VHAP: Adults and children mandatory: Aid to Families with Dependent Children/ Temporary Assistance for Needy Families (AFDC/ TANF), supplemental security income, uninsured adults (150 percent Federal poverty level).

DDMHS Restructuring: DDMHS set formal functional and diagnostic criteria for client eligibility under their programs.

State Managed Care Program Administration

Section 1115 - VHAP: The Office of Vermont Health Access (OVHA) of the Vermont Department of Social Welfare (DSW), which is part of the Agency of Human Services, is responsible for Medicaid administration and is responsible for implementing the VHAP.

OVHA has contracted with two private HMOs under the managed Medicaid program. Both HMOs subcontract with behavioral health organizations to manage and provide behavioral health services on a full-risk basis. One plan has entered into an agreement with the Vermont Behavioral Health Partnership (VBHP), a new public/private nonprofit corporation composed of 10 community mental health, substance abuse, children and family specialty programs, and a commercial behavioral health managed care organization (BHMCO). VBHP manages and provides acute behavioral health services to eligible beneficiaries.

The other HMO has a subcontract with a private, for-profit BHMCO to manage and provide behavioral health care services. Under this arrangement, the BHMCO's responsibilities include utilization review, contracting, claims processing, provider network development, and service provision.

DDMHS Restructuring: DDMHS has begun a major restructuring effort for the public mental health system that involves working with the following State agencies: the Departments of Corrections; Social and Rehabilitation Services; Health; Education; and Aging and Disabilities; the OVHA; and the Office of Alcohol and Drug Abuse Programs.

The restructuring initiative stems from advocates calling for more responsive and effective services, increased concern about use of tax dollars for public services, and funding constraints due to State and Federal economic trends. The goal of the restructuring initiative is to continue to improve services within the context of limited financial growth.

Administrative changes involved in the restructuring effort include new criteria that provider agencies must meet to be designated as a preferred provider by DDMHS. In addition, DDMHS is developing system management tools to be used uniformly throughout the State, including practice guidelines, grievance procedures, system performance and consumer outcome indicators, and quality assurance/quality improvement procedures.

Financing of Plans

Section 1115 - VHAP: VHAP is funded through Medicaid dollars for those individuals eligible under traditional rules, while the population that falls under the expansion to 150 percent Federal poverty level is funded through an increase in cigarette taxes

that is used as the State match for Medicaid. HMOs are capitated, but the State provides stop-loss coverage and reinsurance. Capitation rates are based on age, not severity or experience. Both HMOs offload risk to their behavioral health subcontractors. Both subcontractors receive capitation payments based on those provided to the HMOs.

DDMHS Restructuring: Combining Medicaid and general funds, DDMHS developed a single system of payment (e.g., case rates) for all public sector mental health clients who need long-term-care services. More specifically, major components of the framework for the payment system are

- Case rates for Community Rehabilitation and Treatment (CRT) services and Developmental Services (DS);
- Capitation and fee-for-service payments for emergency services;
- Risk and incentive pools separate from the funds used for CRT and DS case rates and Emergency Services capitation rates; and
- Investment and risk corridor for gains and losses in the CRT, DS, and Emergency Services programs.

Coordination Between Primary and Behavioral Health Care

Section 1115 - VHAP: Coordination is the responsibility of the HMO plans, which use a primary care physician model. Physical health providers communicate with behavioral health providers by agreement; no mandate is in place. After the first behavioral health visit, the primary care physician is involved in referring and approving behavioral specialty services.

DDMHS Restructuring: Not applicable.

Consumer-Family Involvement

Section 1115 - VHAP: Consumer and family involvement has been through advocacy groups and OVHA advisory committees.

DDMHS Restructuring: Under the DDMHS restructuring effort, one of the major goals is to increase family and consumer involvement in evaluation, policy setting, and governance. A new State Quality Performance Council is being formed, and local standing committees for CRT, Children's Services, and DS programs are the primary vehicles through which consumers and family members can participate more fully in the system. In addition, a State Quality Council for Adult Mental Health is also being formed. The composition of this board would be at least 51 percent consumers and family members. It will be concerned with quality issues affecting services for adults with serious mental illness in the managed care program.

Future Plans

Section 1115 - VHAP: A new managed care information system will become operational online by September 1998.

DDMHS Restructuring: See Status of Programs Section.

State Agency Administration

Vermont's Agency of Human Services houses Medicaid, Mental Health, and Substance Abuse. Medicaid falls under the DSW, Mental Health under DDMHS, and Substance Abuse under the Office of Alcohol and Drug Abuse Programs, within the Department of Health.

Currently plans for restructuring within DDMHS include consolidating administration of some children's and substance abuse services and some functions such as management information systems.

Welfare Reform

Vermont's Welfare Restructuring Project, the nation's first statewide demonstration of time-limited welfare, was implemented following receipt of Federal waivers in April 1993 and the General Assembly's enactment of Act 106 in January 1994. Under this project, mandatory drug testing is not required of individuals and if an individual is convicted of a drug-related felony, he or she will be provided TANF assistance until at least June 1998.

County

Not applicable.

Evaluation Findings

Section 1115 - VHAP: Evaluations on cost, outcome, and access are being conducted.

Other Quantitative Data

Not applicable.

VIRGINIA

OVERVIEW

Virginia's first experiences with managed care came in the early 1990s when the Department of Medical Assistance Service (DMAS) implemented the Medallion program. Medallion is a managed fee-for-service (FFS) program available in most parts of the State.

In 1995, the legislature voted to expand the Medallion program and required the DMAS to pilot a mandatory Medicaid managed care plan. DMAS implemented this plan (known as Medallion II) in seven Tidewater localities. Some mental health and substance abuse services are included for Aid to Families with Dependent Children (AFDC) and Aged, Blind, and Disabled populations. HMOs subcontract with community service boards (CSBs) in the current Medallion II areas. A legislative mandate to implement Medallion II in another area directs outpatient services be paid FFS directly to CSBs (outpatient mental health services are excluded from HMO rates).

In addition, the Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS) has implemented a case rate pilot project for individuals with serious mental illness (SMI) and severe emotional disturbance (SED).

Managed Care Programs for Behavioral Health Services

MEDICAID WAIVERS

Section 1915(b) - Medallion II - general health - integrated: Provides physical health as well as limited mental health services.

MEDICAID VOLUNTARY

Not applicable.

OTHER MANAGED CARE PROGRAMS

Priority Populations and Case Rate Funding Pilot - mental health stand-alone: Applies managed care techniques for individual services, planning, and delivery.

Geographic Location

Section 1915(b) - Medallion II: Statewide.

Priority Populations and Case Rate Funding Pilot: Unknown.

Status of Programs

Section 1915(b) - Medallion II: Submitted: unknown; approved: unknown; implemented January 1, 1996. Renewed: unknown.

Priority Populations and Case Rate Funding Pilot: Implemented July 1, 1997.

Medicaid Substance Abuse Services Remaining Fee-For-Service

Outpatient (e.g., day treatment) and residential substance abuse treatment programs for pregnant women and parents with dependent children.

Medicaid Mental Health Services Remaining Fee-For-Service

Inpatient; Institution for Mental Diseases services for individuals under age 22 and over age 65; outpatient (e.g., clinic services); mental health rehabilitation (e.g., targeted case management).

Medicaid Substance Abuse Services in Managed Care Plan

Section 1915(b) - Medallion II: Not applicable.

Medicaid Mental Health Services in Managed Care Plan

Section 1915(b) - Medallion II: Inpatient; outpatient.

Non-Medicaid Substance Abuse Services in Managed Care Plan

Priority Populations and Case Rate Funding Pilot: Not applicable.

Non-Medicaid Mental Health Services in Managed Care Plan

Priority Populations and Case Rate Funding Pilot: Mental health residential; mental health rehabilitation.

Substance Abuse Prevention and Mental Health Promotion in Managed Care Plan

Section 1915(b) - Medallion II: Early and periodic screening, diagnosis, and treatment (EPSDT) services.

Priority Populations and Case Rate Funding Pilot: Unknown.

Populations Covered Under Managed Behavioral Health

Section 1915(b) - Medallion II: Children and adults mandatory: AFDC/TANF (Temporary Assistance for Needy Families) and Supplemental Security Income.

Priority Populations and Case Rate Funding Pilot: Voluntary children and adults: uninsured and underinsured.

State Managed Care Program Administration

Section 1915(b) - Medallion II: The DMAS contracts with private, for-profit health maintenance organizations (HMOs) on a full-risk basis. Some HMOs subcontract with CSBs, which have formed a statewide partnership that represents them as a legal entity with HMOs. This partnership operates under an exemption to antitrust laws and competes for public and private contracts. One HMO has an exclusive contract with five CSBs through this partnership.

Priority Populations and Case Rate Funding Pilot: DMHMRSAS contracts with public CSBs, which are paid a case rate for services provided.

Financing of Plans

Section 1915(b) - Medallion II: Medicaid funds this program. DMAS makes capitated payments to HMOs under a full-risk arrangement. The HMOs are paid a monthly fee per member. These rates are based on pre-HMO Medicaid costs. The rates are broken down by age, sex, locality, and if a client is aged, disabled, or other.

Priority Populations and Case Rate Funding Pilot: State-only dollars funds this pilot. The State pays CSBs a case rate for services provided.

Coordination Between Primary and Behavioral Health Care

Section 1915(b) - Medallion II: Coordination of these services is performed according to the HMO procedures.

Priority Populations and Case Rate Funding Pilot: Not applicable.

Consumer-Family Involvement

Section 1915(b) - Medallion II: One subcontracted CSB has established its own hotline for managed-care-related complaints and has served as an ombudsman program in its service area.

Priority Populations and Case Rate Funding Pilot: Unknown. Strategies for Increasing Client and Family Involvement is a project that increases consumer and family involvement and participation in service planning, delivery, and evaluation of publicly funded mental health, mental retardation, and substance abuse services. The project uses a Best Practices Report Card to evaluate progress in this area.

Future Plans

Section 1915(b) - Medallion II: Unknown.

Priority Populations and Case Rate Funding Pilot: Unknown.

State Agency Administration

The Medicaid authority is the DMAS. The mental health and substance abuse authority is the DMHMRSAS.

Welfare Reform

Virginia filed a State plan under P.L. 104-193 with the U.S. Department of Health and Human Services on December 6, 1996. The plan became effective February 1, 1997. The program denies benefits to drug felons but does not test recipients for drug use.

County

Not applicable.

Evaluation Findings

Performance and Outcome Measurement System (POMS): The State Medicaid agency has developed a mechanism for the routine assessment of consumer outcomes and provider performance, frequently as part of an overall strategy of managed care. Through POMS, provider and system performance is assessed on several dimensions, including access to services, quality/appropriateness of care, consumer outcomes, inter-system performance, and consumer/family participation. A pilot project is currently being conducted to test the effectiveness of POMS and identify needed refinements.

Other Quantitative Data

Not applicable.

WASHINGTON

OVERVIEW

Washington currently operates two managed care programs affecting public sector behavioral health services. First, the Integrated Community Mental Health Program is an integrated managed care waiver program for community inpatient and outpatient mental health and rehabilitation services. Washington's statutorily based local mental health authorities are responsible for the program (Regional Support Networks (RSNs)). Some mental health authorities manage the program themselves, while others have contracted with private administrative services organizations (ASOs).

To date, all RSNs established by Washington's Mental Health Reform Act of 1989 have chosen to become prepaid health plans (PHPs).

Second, Washington's basic health plan (BHP) is a State-sponsored physical health managed care program that provides some mental health/substance abuse benefits to uninsured individuals.

Chemical dependency services are not included under a specific managed care program at this time, except for those limited services provided under BHP for the uninsured and underinsured. All Medicaid substance abuse services provided to public assistance recipients are managed by the Division of Alcohol and Substance Abuse (DASA) using managed care principles but not contracted through managed care entities. These services are provided on a fee-for-service basis.

Managed Care Programs for Behavioral Health Services

MEDICAID WAIVERS

Section 1915(b) - Integrated Community Mental Health Program - mental health stand-alone: Provides capitated community psychiatric inpatient, outpatient, and rehabilitation services.

MEDICAID VOLUNTARY

Not applicable.

OTHER MANAGED CARE PROGRAMS

BHP - integrated: State-sponsored program that provides limited mental health and substance abuse services to working individuals without insurance and other uninsured individuals.

Geographic Location

Section 1915(b) - Integrated Community Mental Health Program: Statewide.

BHP: Statewide.

Status of Programs

Section 1915(b) - Integrated Community Mental Health Program: Submitted December 1996; approved and implemented July 1, 1997.

BHP: Implemented behavioral health services in 1995.

Medicaid Substance Abuse Services Remaining Fee-For-Service

Hospital-based detoxification; opiate treatment; outpatient.

Medicaid Mental Health Services Remaining Fee-For-Service

Inpatient; rehabilitation; pharmacy; support (e.g., personal care); outpatient (e.g., individualized treatment services); inpatient mental health care for those under age 21.

Medicaid Substance Abuse Services in Managed Care Plan

Section 1915(b) - Integrated Community Mental Health Program: Not applicable.

Medicaid Mental Health Services in Managed Care Plan

Section 1915(b) - Integrated Community Mental Health Program: Inpatient (e.g., psychiatric services); crisis; mental health support (e.g., stabilization services, medication management); outpatient (e.g., individual and group treatment services, adult day treatment, intake evaluation, special population evaluation, interdisciplinary evaluation for nursing home residents, psychological assessment); rehabilitation (e.g., adult and child acute diversion services, child and adolescent day treatment, family therapy).

In addition, higher-need clients receive individualized care planning (e.g., intensive community support, wraparound services, and other comparable services that do not necessarily involve treatment teams).

Non-Medicaid Substance Abuse Services in Managed Care Plan

BHP: Chemical dependency treatment benefits (e.g., inpatient, residential, outpatient) are limited to a maximum of $5,000 in a 24 consecutive calendar month period and a lifetime maximum of $10,000.

Non-Medicaid Mental Health Services in Managed Care Plan

BHP: Inpatient (up to 10 days per calendar year); outpatient (up to 12 visits per year).

Substance Abuse Prevention and Mental Health Promotion in Managed Care Plan

Section 1915(b) - Integrated Community Mental Health Program: RSNs use State-only and Federal block grant dollars for prevention services. Typically, these services fall under the rehabilitation service option.

BHP: Unknown

Populations Covered Under Managed Behavioral Health

Section 1915(b) - Integrated Community Mental Health Program: Aid to Families with Dependent Children/ Temporary Assistance for Needy Families (AFDC/ TANF), Supplemental Security Income, categorically and medically needy; optional expansion pregnant women up to 185 percent Federal poverty level (FPL) and children up to 200 percent FPL.

BHP: Underinsured and uninsured.

State Managed Care Program Administration

Section 1915(b) - Integrated Community Mental Health Program: The Integrated Community Mental Health Program is administered by the Mental Health Division (MHD) within the Department of Social and Health Services. The MHD has contracted with 14 PHPs that are regional county-based organizations (e.g., RSNs). MHD oversees and administers the statewide public system (e.g., sets policy; ensures an accountable system; defines covered lives and minimum services; licenses providers; sets performance standards and outcomes; ensures maximum amount of services; and operates state hospitals). RSNs are designated as the single point of local responsibility for mental health services under State statute. The 14 RSNs that operate the managed care program are single or multiple county administrative organizations (6 are multiple county administrative organizations). These RSNs subcontract with community mental health centers for service delivery. Two RSNs have partnerships with private behavioral health managed care organizations (BHMCOs). The RSNs are accountable to the Mental Health Division of the Department of Social and Health Services. The RSN's role is as purchaser and manager of services. They ensure a seamless system of mental health services to meet individuals' needs. Under the integrated system, RSNs

- Create and maintain administrative structure across the PHP (central advisory board, central fiscal structure);
- Ensure access for all covered lives;
- Develop and maintain provider network (The provider network depends on the geographical location, whether urban, suburban, or rural.

The State has licensed more than 150 agencies who do business in some form with the 14 RSNs.);

- Maintain a case management system (e.g., prior authorization, concurrent review and retrospective review);
- Ensure consumer satisfaction;
- Ensure outcomes and provide MHD with data on outcomes;
- Maintain profiling and credentialing system; and
- Administer a portion of State hospital budget.

BHP: The Washington State Health Care Authority (HCA) contracts with 14 health plans under BHP.

Financing of Plans

Section 1915(b) - Integrated Community Mental Health Program: This program is funded by Medicaid, Federal block grant dollars, and State-only money. RSNs use the Federal block grant and State-only dollars for emergency services, intake, and the general assistance population. RSNs are capitated and at risk. There is no reinsurance or risk sharing pool.

Contracts with PHPs/RSNs are on a capitated basis for the provision of all inpatient and outpatient mental health services. Medicaid provides funding for mental health services included in the capitation rate. These funds cover approximately one visit per client per month.

The subcontracted BHMCOs are provided an administrative fee that reflects the number of people authorized for services at the beginning of each month. The BHMCO shares no financial risk with the RSN. Savings are reinvested into a system for the creation of innovative programs to assist clients with mental illness.

Washington hired a private actuarial firm to calculate the capitation rates. The rates are based on expenditures incurred for outpatient community mental health rehabilitation and community psychiatric inpatient services. The rates were calculated RSN by RSN and category by category, with separate inpatient and outpatient rates for Medicaid eligibles. RSNs are given a per member per month payment that is split into inpatient and outpatient. Outpatient is further subdivided into children and adults, with seven risk categories for each.

The reimbursement mechanism for providers varies by RSN. King County, for example, has a tier system in which they give an allotted amount to providers. In general, however, most RSNs do performance- or outcome-based contracting.

BHP: The plan establishes on a prepaid capitated basis for basic health care services administered by the Washington State HCA. Payment for coverage is made through monthly premiums (full premiums or reduced premiums with State subsidy) and co-pays at the time of service. The amount of the monthly premium is based on age, family size, income, and health plan chosen.

Coordination Between Primary and Behavioral Health Care

Section 1915(b) - Integrated Community Mental Health Program: Unknown.

Consumer-Family Involvement

Section 1915(b) - Integrated Community Mental Health Program: The RSNs' contracts specify that 50 percent plus one consumer or family member will be represented on their boards. Additionally, Regional Support Advisory Committees have been formed that have consumer and family member participation.

BHP: Unknown.

Future Plans

Section 1915(b) - Integrated Community Mental Health Program: None.

BHP: Washington State Psychological Association is working on legislation that would establish a task force to study the advisability of managed care programs for public mental health and substance abuse programs.

★ *New Program Under Development:* The State requested a waiver of the Institution for Mental Diseases (IMD) exclusion for pregnant women in residential care for substance abuse treatment.

★ *New Program Under Development:* Washington Department of Health will be conducting mandated benefit sunrise review on mental health parity.

★ *New Program Under Development:* Washington State HCA is using a RWJ grant to test health-status-based risk adjustment as a new system of reimbursement; that is, managed care organizations

(MCOs) will receive higher premiums for sicker populations of patients and lower premiums for healthy patients. The ultimate goal of the project is to have MCOs manage care, not risk.

State Agency Administration

Washington's Medicaid, Mental Health, and Substance Abuse agencies are all housed under an umbrella agency, the Department of Social and Health Services. Medicaid is within the Medical Assistance Administration, Mental Health within the Mental Health Division, and Substance Abuse within the DASA.

Welfare Reform

Welfare reform legislation was enacted in Washington State during the 1997 legislative session. The current legislation rescinded the previous State statute and required conformity with the Federal welfare act. The current legislation requires participation in treatment as a condition of eligibility for welfare recipients who are chemically dependent and need treatment. Drug testing is not mandatory for TANF eligibles. The plan also provides welfare benefits to persons convicted of a drug-related felony after August 22, 1996, under specific conditions, one being participation in chemical dependency treatment. Mental health services are also provided to these individuals; however, these services are considered part of the Medicaid service package.

County

- Clark County: Clark County contracts with a commercial MCO to handle prior authorization, triage services, and day-to-day management of the program. Clark County is one of only two areas running their own program because of their population mass.
- Unified Services Initiative: King County Mental Health Division integrates management of both inpatient and outpatient mental health services. The Seattle/King County Public Health Department created a Bureau of Unified Services that has been responsible for providing a single access point for service delivery to clients. The mission statement is centered on the theory of "no wrong door," meaning that clients who need services can access care no matter what "door" they enter.
- King County: Under the County Executive, King County Human Resources, the Division of Children and Family Services, King County Mental Health Prepaid Health Plan, King County Department of Alcohol and Substance Abuse, Department of Developmentally Delayed, Division of Youth Services, and School Districts will blend their funds and provide child welfare services (including mental health and substance abuse services) under an ASO model using a case rate reimbursement system.

Evaluation Findings

- The Washington State Institute for Public Policy will help the State evaluate outcomes associated with the State's welfare reform program.
- Additionally, State legislation created the Washington Institute for Mental Health Research and Training, which conducted an analytical evaluation of RSN implementation.
- DASA developed a statewide outcome-based management information system that measures the status of client health and social functionality indicators across time.
- DASA operates a management information system that collects client demographic information, services provided to clients, and social and behavioral milestones of client status at admission and discharge.
- DASA goes beyond outcome measures afforded by the management information system by conducting studies that measure cost offsets and health status improvement.
- DASA conducts an ongoing comprehensive 6-month follow-up of clients in all publicly funded treatment programs.

Other Quantitative Data

Not applicable.

WEST VIRGINIA

OVERVIEW

West Virginia currently does not have a Federal waiver for managed behavioral health care services. However, behavioral health services are being managed under the New Directions in Medicaid Services Initiative, a program that requires providers to administer functional assessment instruments to service recipients on a quarterly basis. New Directions targets Medicaid clinic and rehabilitation services. Providers administer functional assessment instruments to service recipients on a quarterly basis during the first year of the initiative. Data collected on the degree of impairment and clinical outcomes of recipients are then used to match level of care to level of need for all behavioral health treatment services, regardless of the source of funding. This will lay the groundwork for the establishment of case rates.

During Phase II, utilization management and utilization review mechanisms, prior authorization, and care criteria services will be established.

Managed Care Programs for Behavioral Health Services

MEDICAID WAIVERS

Not applicable.

MEDICAID VOLUNTARY

New Directions in Medicaid Services Initiative - Medicaid program - behavioral health stand-alone: The New Directions Initiative has four goals: 1) to integrate various funding streams so that they support a coherent system of behavioral health services; 2) to improve quality of behavioral health services for children and adults; 3) to ensure that consumers receive the services they need, when needed and in the amount needed; and 4) to establish a rational system of cost containment.

OTHER MANAGED CARE PROGRAMS

Not applicable.

Geographic Location

New Directions in Medicaid Services Initiative: Statewide.

Status of Programs

New Directions in Medicaid Services Initiative: Implemented November 1996.

Medicaid Substance Abuse Services Remaining Fee-For-Service

Outpatient; acute detoxification.

Medicaid Mental Health Services Remaining Fee-For-Service

Inpatient; outpatient (e.g., clinic services); Institution for Mental Diseases services for individuals age 65 and over and age 21 and under; mental health rehabilitation (e.g., targeted case management).

Medicaid Substance Abuse Services in Managed Care Plan

New Directions in Medicaid Services Initiative: Outpatient (e.g., clinic); residential substance abuse treatment programs (e.g., non-hospital-based settings).

Medicaid Mental Health Services in Managed Care Plan

New Directions in Medicaid Services Initiative: Outpatient (e.g., clinic); mental health rehabilitation (e.g., case management services).

Non-Medicaid Substance Abuse Services in Managed Care Plan

Not applicable.

Non-Medicaid Mental Health Services in Managed Care Plan

Not applicable.

Substance Abuse Prevention and Mental Health Promotion in Managed Care Plan

New Directions in Medicaid Services Initiative: Not applicable.

Populations Covered Under Managed Behavioral Health

New Directions in Medicaid Services Initiative: Children and adults voluntary: Medicaid populations: Aid to Families with Dependent Children/Temporary Assistance for Needy Families (AFDC/TANF), Supplemental Security Income and State mental health allocation populations: general assistance.

State Managed Care Program Administration

New Directions in Medicaid Services Initiative: The Department of Health and Human Resources (DHHR) has lead responsibility for this program and contracts with any willing provider. Providers are not at risk for services; however, they are required to use standardized functional assessment instruments to determine medical necessity. The data reported from the instruments are used by consensus panels to determine service packages that match level of care and level of need. The intent is to use the data collected in Phase I of the initiative to establish the standards for utilization management statewide.

During Phases II and III, a defined set of service packages will be developed by consensus panels and implemented. Consensus panels are composed of consumers, family members, providers, and service system experts. They provide guidance to clinicians on acceptable service intensity and cost given the level of impairment. The service delivery models will begin to be evaluated in relation to best practices.

Financing of Plans

New Directions in Medicaid Services Initiative: The source of funds is Medicaid dollars. At present, the program does not involve capitation. The proposed methodology will develop case rates and capitated rates from the data being collected related to service utilization, cost, and the relationship to functional impairment. Providers are not currently at risk.

Coordination Between Primary and Behavioral Health Care

New Directions in Medicaid Services Initiative: Unknown.

Consumer-Family Involvement

New Directions in Medicaid Services Initiative: The New Directions Initiative was designed by engaging a variety of stakeholders, including DHHR representatives, providers of Medicaid-reimbursed behavioral health services, and consumers and family members. A consumer satisfaction evaluation is being managed by consumer groups who are coordinating their efforts with the DHHR Office of Behavioral Health Services (OBHS). In addition, a report card on the behavioral health system will be issued under this initiative. It will provide information on the level of functioning of consumers, some short-term outcomes, cost, and consumer and family satisfaction for each provider and for the overall system. Consumers are included in all aspects and serve on the Quality Control Council, consensus panels, and design teams. The planning process has been characterized by representatives of consumers and families joining with OBHS staff to develop the initiative. Consumer and family organizations have been strengthened owing to the implementation of a Leadership Academy and their increased involvement with the Mental Health Planning Council and Council Plus.

Future Plans

New Directions in Medicaid Services Initiative: The State hopes to begin paying providers case rates or capitation rates for all clients in the program.

State Agency Administration

The Medicaid authority is the Bureau for Medical Services, within the Department of Health and

Human Services. The mental health authority, the OBHS, and the substance abuse authority, the Division of Alcoholism and Drug Abuse, are both also housed in the Department of Health and Human Services.

Welfare Reform

West Virginia filed a state plan under P.L. 104-193 with the U.S. Department of Health and Human Services on November 27, 1996, which became effective January 11, 1997. The program denies benefits to drug felons but does not test recipients for drug use.

County

Not applicable.

Evaluation Findings

Not applicable.

Other Quantitative Data

Not applicable.

WISCONSIN

OVERVIEW

Wisconsin is piloting a number of managed care plans designed around a specifically defined population. The State has seven managed behavioral health care programs, one of which is pending Health Care Financing Administration (HCFA) approval. The Medicaid agency operates an Aid to Families with Dependent Children/Healthy Start health maintenance organization program that includes mental health and substance abuse services and five specialized managed care programs. Two county-based programs are behavioral health stand-alone plans for children with severe emotional disturbance (SED). The remaining three managed care programs are designed for special populations (e.g., elderly, physically disabled, AIDS) and combine physical health and behavioral health services. The pending Section 1115 waiver will provide managed physical as well as behavioral health services to the uninsured and underinsured.

Managed Care Programs for Behavioral Health Services

MEDICAID WAIVERS

Section 1915(b) - Medicaid HMO Program - integrated: Program that covers physical health as well as acute care mental health and substance abuse services.
Section 1115 - BadgerCare - integrated: Provides system of care to uninsured and underinsured families.

MEDICAID VOLUNTARY

Children Come First (CCF) - behavioral health stand-alone: Covers mental health and substance abuse services for children with SED in Dane County.
WrapAround Milwaukee (WAM) - behavioral health stand-alone: Covers mental health and substance abuse services for children with SED in Milwaukee County.
Independent Care - (I-Care) - integrated: Covers acute care mental health and substance abuse services to the Supplemental Security Income (SSI) population.
Wisconsin Partnership Program (WI Partnership) - integrated: Covers acute care mental health and substance abuse services to the SSI population.
Program for All-Inclusive Care for the Elderly (PACE) - integrated: Covers acute care mental health and substance abuse services to frail elderly individuals.

OTHER MANAGED CARE PROGRAMS

Not applicable.

Geographic Location

Section 1915(b) - Medicaid HMO Program: Statewide.
Section 1115 - BadgerCare: Statewide.
CCF: Dane County.
WAM: Milwaukee County.
I-Care: Milwaukee County.
WI Partnership: Dane, Milwaukee, and EauClaire Counties.
PACE: Milwaukee and Dane Counties.

Status of Programs

Section 1915(b) - Medicaid HMO Program: Approved September 27, 1994; implemented September 30, 1994.

Section 1115 - BadgerCare: Waiver submitted March 21, 1998. Pending HCFA approval. Implementation of Phase I set for July 1, 1998.

CCF: Implemented April 1993.
WAM: Implemented March 1997.
I-Care: Implemented July 1, 1994.

WI Partnership: Implemented October 1, 1995.

PACE: Implemented in Milwaukee: November 1989; in Dane: January 1995.

Medicaid Substance Abuse Services Remaining Fee-For-Service

Outpatient; detoxification; opiate treatment; inpatient; transportation.

Medicaid Mental Health Services Remaining Fee-For-Service

Inpatient; Institution for Mental Diseases (IMD) services for individuals under age 21; crisis; mental health support (e.g., community support programs, targeted case management); pharmacy; rehabilitation (e.g., child/adolescent day treatment); residential (e.g., in-home psychotherapy); outpatient (e.g., nonphysician providers).

Medicaid Substance Abuse Services in Managed Care Plan

Section 1915(b) - Medicaid HMO Program: The following substance abuse services are covered: outpatient; detoxification; opiate treatment; inpatient; transportation.

Section 1115 - BadgerCare: The following substance abuse services are covered: outpatient; detoxification; opiate treatment; inpatient; transportation.

Medicaid Mental Health Services in Managed Care Plan

Section 1915(b) - Medicaid HMO Program: The following mental health services are covered: inpatient, IMD services for individuals under age 21; crisis; mental health support (e.g., community support programs, targeted case management); pharmacy; rehabilitation (e.g., child/adolescent day treatment); residential (e.g., in-home psychotherapy); outpatient (e.g., nonphysician providers).

Section 1115 - BadgerCare: The following mental health services are covered: inpatient; IMD services for individuals under age 21; crisis; mental health support (e.g., community support programs, targeted case management); pharmacy; rehabilitation (e.g., child/adolescent day treatment); residential (e.g., in-home psychotherapy); outpatient (e.g., nonphysician providers).

Non-Medicaid Substance Abuse Services in Managed Care Plan

CCF: Provides the following substance abuse services: outpatient, detoxification, opiate treatment, inpatient, transportation.

WAM: Provides the following substance abuse services: outpatient; detoxification, opiate treatment, inpatient, transportation.

I-Care: Provides the following substance abuse services: outpatient, detoxification, opiate treatment, inpatient, transportation.

WI Partnership: Provides the following substance abuse services: outpatient, detoxification, opiate treatment, inpatient, transportation.

PACE: Provides the following substance abuse services: outpatient, detoxification, opiate treatment, inpatient, transportation.

Non-Medicaid Mental Health Services in Managed Care Plan

CCF: Provides the following mental health services: inpatient; IMD services for individuals under age 21; crisis; mental health support (e.g., community support programs, targeted case management); pharmacy; rehabilitation (e.g., child/adolescent day treatment); residential (e.g., in-home psychotherapy); outpatient (e.g., nonphysician providers).

WAM: Provides the following mental health services: inpatient; IMD services for individuals under age 21; crisis; mental health support (e.g., community support programs, targeted case management); pharmacy; rehabilitation (e.g., child/adolescent day treatment); residential (e.g., in-home psychotherapy); outpatient (e.g., nonphysician providers).

I-Care: Provides the following mental health services: inpatient; IMD services for individuals under age 21; crisis; mental health support (e.g., community support programs, targeted case management); pharmacy; rehabilitation (e.g., child/adolescent day treatment); residential (e.g., in-home psychotherapy); outpatient (e.g., nonphysician providers).

WI Partnership: Provides the following mental health services: inpatient; IMD services for individuals under age 21; crisis; mental health support (e.g., community support programs; targeted case management); pharmacy; rehabilitation (e.g., child/adolescent day treatment); residential (e.g., in-home

psychotherapy); outpatient (e.g., nonphysician providers).

PACE: Provides the following mental health services: inpatient; IMD services for individuals under age 21; crisis; mental health support (e.g., community support programs; targeted case management); pharmacy; rehabilitation (e.g., child/adolescent day treatment); residential (e.g., in-home psychotherapy); outpatient (e.g., nonphysician providers).

Substance Abuse Prevention and Mental Health Promotion in Managed Care Plan

Section 1915(b) - Medicaid HMO Program: Unknown.

Section 1115 - BadgerCare: Unknown.

CCF: Unknown.

WAM: Unknown.

I-Care: Unknown.

WI Partnership: Unknown.

PACE: Unknown.

Populations Covered Under Managed Behavioral Health

Section 1915(b) - Medicaid HMO Program: Adults and children mandatory: Aid to Families with Dependent Children/Temporary Assistance for Needy Families (AFDC/TANF); pregnant women and children up to 165 percent Federal poverty level (FPL) (Healthy Start); dually eligible Medicare/Medicaid.

Section 1115 - BadgerCare: Adults and children mandatory: uninsured and underinsured whose incomes fall below 185 percent FPL. Families whose incomes are 143 percent FPL will be required to pay monthly premiums of no more than 3.5 percent of their family income.

CCF: Voluntary: AFDC/TANF child and adolescent clients of Dane County Human Services Department.

WAM: Voluntary: AFDC/TANF child and adolescent clients of Milwaukee County Human Services Department.

I-Care: Voluntary for individuals age 15 and over: SSI, dually eligible Medicare/Medicaid. WI partnership: Voluntary: SSI, dually eligible Medicare/Medicaid.

PACE: Voluntary: SSI, dually eligible Medicaid/Medicare.

State Managed Care Program Administration

Section 1915(b) - Medicaid HMO Program: Medicaid contracts with 19 HMOs licensed by the Wisconsin Office of the Commissioner of Insurance for service provision of this program. The HMO panel is open.

Section 1115 - BadgerCare: The program administration will be the same as under the 1915(b) waiver. BadgerCare will essentially be composed of two delivery systems: An HMO system and a subsidized employer-based system. Those family members who qualify for AFDC/TANF will fall into the HMO system, and those families with access to employer coverage will be subsidized in addition to wraparound services provided to bring this population up to Medicaid coverage.

CCF: Medicaid contracts with Dane County for administration of this program. Therefore, Dane County is responsible for the operational administration of the program and subcontracts for mental health and substance abuse services.

WAM: Medicaid contracts with Milwaukee County for administration of this program. Therefore, Milwaukee County is responsible for the operational administration of the program and subcontracts for mental health and substance abuse services.

I-Care: A state-licensed HMO and a community-based organization formed a partnership to administer this program.

WI Partnership: Unknown.

PACE: Unknown.

Financing of Plans

Section 1915(b) - HMO Program: Medicaid pays full capitation for all medical services covered by Medicaid except prenatal care coordination and common carrier transportation. Two capitation rates, one for AFDC and one for Healthy Start, are used. Capitation rates vary by regions. Ten rate regions divide the State.

Section 1115 - BadgerCare: BadgerCare will be funded through Medicaid dollars, State tax revenues, and premiums. Anticipated savings of 5 to 8 percent were built into the capitation rate. HMOs will be paid a per member per month capitation rate. Some services will still be provided on a fee-for-service basis. Cost sharing will be a component

of BadgerCare; namely, families with incomes in excess of 143 percent FPL will pay a premium of no more than 3.5 percent of family income. Premium shares are to be collected through wage withholding or an alternative, automated system.

CCF: CCF provides behavioral health services under a risk-based, prepaid contract. Dane County Human Services provides 95 percent of fee-for-service costs for mental health and substance abuse services in addition to providing payment to cover the non-Medicaid services.

WAM: WAM, which is an expansion of CCF, was initially a 5-year Center for Mental Health Services grant. The program is now jointly funded through the Department of Health and Family Services (DHFS) and Milwaukee County Department of Human Services (DHS). Milwaukee County DHS provides 95 percent of fee-for-service costs for mental health and substance abuse services in addition to providing payment to cover the non-Medicaid services.

I-Care: The State pays a capitation rate of 100 percent of the Medicaid fee-for-service costs per member per month.

WI Partnership: Unknown.

PACE: Unknown.

Coordination Between Primary and Behavioral Health Care

Section 1915(b) - Medicaid HMO Program: Under the Medicaid HMO program, the HMOs are responsible for care coordination.

Section 1115 - BadgerCare: Unknown.

CCF: Under the voluntary CCF program, management and integration of mental health care and community support services are coordinated through a primary case coordinator.

WAM: Unknown.

I-Care: Unknown.

WI Partnership: Unknown.

PACE: Unknown.

Consumer-Family Involvement

Section 1915(b) - Medicaid HMO Program: Unknown.

Section 1115 - BadgerCare: Unknown.

CCF: Under the CCF program, the County is planning efforts to improve the health care delivery system through member feedback through focus groups, consumer advisory councils, member participation on the governing board, the quality improvement committees or other committees, or task forces related to evaluating services.

WAM: Unknown.

I-Care: Unknown.

WI Partnership: Unknown.

PACE: Unknown.

Future Plans

Section 1915 (b) - Medicaid HMO Program: Wisconsin Medicaid is in the early planning stages of expanding managed behavioral health care for a significant portion of the non-AFDC population. This plan may also include Medicare-eligible individuals and uninsured or underinsured individuals currently being served by counties. As such, this program may go beyond Medicaid to cover all individuals currently served by the public sector.

Section 1115 - BadgerCare: Implement Phase II.

CCF: None.

WAM: None.

I-Care: Persons with disabilities who are Medicaid eligible through SSI will have the option of receiving health care through the managed care system voluntarily. The individual will receive care through the fee-for-service system if he or she does not choose the managed care system. I-Care will expand to Kenosha and Racine Counties by January 1999 to tailor the needs by requiring

- Multiple medications to treat chronic conditions;
- Intensive coordination, case management, and medication management services; and
- Assistance with housing, employment, and relationship issues.

DHFS is currently developing a certification document, contract language, and capitation rates for managed care organizations that choose to participate. If this SSI Medicaid managed care program proves successful in Kenosha and Racine Counties, the State will expand this option statewide.

WI Partnership: None.

PACE: None.

★ *New Program Under Development:* The Governor's Blue Ribbon Commission on Mental Health consists of representatives from the government, the mental health professions, and the public and private sectors who have an interest in the

future direction of mental health care in Wisconsin. They developed a long-term plan for mental health services. Some of their suggestions included the following:

- Organize the mental health system around the concept of recovery;
- Identify persons to be served and divide those individuals into different groups based on the level of need for services provided;
- Increase consumer involvement in all levels of planning and oversight of the system;
- Identify consumer-level outcomes that should be used to measure performance of the system;
- Set aside funding for prevention activities;
- Outline core services that should be part of the system; there should be creativity and flexibility in designing individualized services around the core services;
- Address stigma;
- Merge State, county, and Medicaid dollars that are currently providing mental health treatment;
- Build on the current county-based system as the development of managed care in the area continues; and
- Examine Medicaid waivers to allow for behavioral health managed care and supporting pilot programs.

★ *New Program Under Development:* Wisconsin is developing a long-term care redesign proposal that is a thorough, statewide overhaul in the way long-term-care services are managed and delivered to the elderly and people with mental, physical, or developmental disabilities. Wide input is being sought from consumer, advocate, and provider groups. The changes proposed would not take effect until around the year 2000.

State Agency Administration

DHFS consists of five divisions: Children and Family Services; Supportive Living; Care and Treatment Facilities; Health; and Management and Technology. The Division of Supportive Living houses mental health and substance abuse under the Bureau of Community Mental Health and the Bureau of Substance Abuse Services, respectively. Within the Division of Health, the Bureau of Health Care houses Medicaid.

Welfare Reform

Wisconsin Works (W-2) is Wisconsin's welfare reform plan based on work that has been in statewide operation since September 1997. Physical health care under W-2 is delivered through managed care providers. Coverage is available to all low-income families, including children through age 18. Families pay a portion of their health care premium based on income, with the State paying the difference. Families with low incomes will pay only a nominal portion of the premium amount, which will rise as income increases. Working families who are eligible for employer-provided coverage are required to accept it (or other private coverage). Also included under this plan is the denial of TANF to individuals convicted of drug felonies. Legislation is pending that would require mandatory drug testing of all welfare clients.

County

Not applicable.

Evaluation Findings

Unknown.

Other Quantitative Data

Not applicable.

WYOMING

OVERVIEW

Wyoming does not operate any Medicaid waivers for behavioral health care and has never applied for such a waiver. Wyoming has no plans for managed behavioral health care. However, it is considering various reforms for the public mental health system.

Managed Care Programs for Behavioral Health Services

MEDICAID WAIVERS

Not applicable.

MEDICAID VOLUNTARY

Not applicable.

OTHER MANAGED CARE PROGRAMS

Not applicable.

Geographic Location

Not applicable.

Status of Programs

Not applicable.

Medicaid Substance Abuse Services Remaining Fee-For-Service

Residential substance abuse treatment programs (e.g., non-hospital-based care settings).

Medicaid Mental Health Services Remaining Fee-For-Service

Inpatient; mental health rehabilitation (e.g., targeted case management).

Medicaid Substance Abuse Services in Managed Care Plan

Not applicable.

Medicaid Mental Health Services in Managed Care Plan

Not applicable.

Non-Medicaid Substance Abuse Services in Managed Care Plan

Not applicable.

Non-Medicaid Mental Health Services in Managed Care Plan

Not applicable.

Substance Abuse Prevention and Mental Health Promotion in Managed Care Plan

Not applicable.

Populations Covered Under Managed Behavioral Health

Not applicable.

State Managed Care Program Administration

Not applicable.

Financing of Plans

Not applicable.

Coordination Between Primary and Behavioral Health Care

Not applicable.

Consumer-Family Involvement

Not applicable.

Future Plans

★ *New Program Under Development:* The Governor has endorsed recommendations of the Select Committee and Partnership on Mental Health to reform the mental health system. However, his support is conditioned upon targeting services to adults with severe and persistent mental illness and children with severe emotional disturbances as its first priority. First-year funding for targeted services began July 1, 1997.

State Agency Administration

The Medicaid authority in Wyoming is the Division of Health Care Financing, which is under the Department of Health. The mental health and substance abuse authority is the Division of Behavioral Health, within the Department of Mental Health.

Welfare Reform

Wyoming filed a state plan under P.L. 104-193 with the U.S. Department of Health and Human Services on October 16, 1996, which became effective January 1, 1997. The program provides benefits to drug felons and does not test recipients for drug use.

County

Not applicable.

Evaluation Findings

Not applicable.

Other Quantitative Data

Not applicable.

Appendix A: Project Background

Between 1995 and 1997, under contract from SAMHSA's Office of Managed Care, a prototype system was created to track and monitor managed mental health and substance abuse care in the public sector. The prototype was initiated by the Mental Health Policy Research Center with the George Washington University Center. During that time, project efforts focused on collecting baseline information related to Medicaid managed behavioral health care waivers. As it became available, information on welfare reform, non-Medicaid managed care, and State agency reorganization was added to the database.

In September 1997, a new 3-year contract was awarded to do the following:

- Update baseline information on Medicaid managed care, welfare reform, and non-Medicaid programs;
- Expand data collection to include new priorities and new types of information;
- Develop new products to disseminate information; and
- Analyze data from the national database.

During the initial project year, new and expanded data were collected and added to the database in the following areas:

- Role of substance abuse prevention and mental health promotion in managed care programs;
- Role and responsibilities of managed care entities, providers, and States;
- Risk arrangements and managed behavioral health care programs (provider and managed care entity);
- Characteristics of managed behavioral health care provider networks; and
- Administration, organization, and financing of non-Medicaid managed care programs operated by single State authorities for mental health and/or substance abuse.

Another important addition to the 1998 Tracking System is the creation of a database that "codes" the Nation's publicly funded managed behavioral programs. The 1997 profiles were reviewed and analyzed for information regarding their status, implementation, financing, risk, scope, populations, covered services, and relation to physical health benefits. Analyses of the 1997 data are included in Section III of this document. The analysis compares and contrasts various features of managed behavioral health (MBH) programs and explores the relationship of managed care status and features with State "environmental" variables. For example, it categorizes MBH programs according to such factors as whether the State's administrative responsibilities are "county-dominated" or centralized at the State level, the extent of Medicaid managed care penetration in physical health, and growth in mental health and substance expenditures as a precursor to managed care development. This initial analysis is intended to shed further light on the extent and design of MBH programs and to illustrate State factors in the financing and management of behavioral health services. Analysis of the 1998 profiles will be conducted during the second project year (beginning October 1, 1998).

Appendix B: Glossary

administrative services only (ASO) contract A contract between an insurance company and a self-funded plan under which the insurance company performs administrative services only (e.g., claims processing).

AFDC/TANF Aid to Families with Dependent Children and Temporary Assistance for Needy Families have been grouped together because although TANF has replaced the AFDC terminology, eligibility for Medicaid still relies on previous AFDC eligibility established prior to the welfare reform legislation that created TANF. Furthermore, individuals who met eligibility criteria that were in effect on July 16, 1996, are eligible for Medicaid. The eligibility criteria are based on a percentage of the Federal poverty level (FPL); this percentage varies from State to State. Specific populations covered under AFDC/TANF include children, pregnant women, and low-income families.

behavioral health Care provided for the treatment of mental and/or substance abuse disorders. Substance abuse includes alcohol and drugs.

behavioral health managed care organization (BHMCO) An organization that manages, administers and/or provides mental health and substance abuse benefits carved out from the general health plan that is provided by insurers and self-insured companies.

capitation/capitation fee/capitation payment A prospective payment method that pays the managed care entity (or provider) a uniform amount for each person served, usually on a monthly basis.

case rate A "package price" for a specific procedure or diagnosis-related group; for example, the physician case rate for obstetrics includes all prenatal visits, labor, delivery, and one postpartum examination.

clinical criteria Often, non-Medicaid programs do not base program eligibility on income thresholds but on clinical criteria, such as serious mental illness, at risk for placement in foster home, or history of substance abuse.

comprehensive care Provision of a broad spectrum of health services that are required to prevent, diagnose, and treat physical and mental illnesses and to maintain health (includes physicians' services and hospitalization).

consumer A person who receives and/or purchases services; sometimes differentiated from "customer" in that a consumer also advocates for service quality and appropriateness, whereas a customer is any person receiving and/or purchasing services.

co-payment The portion of a claim or medical expense that a member (or covered insured) must pay out of pocket, usually a fixed amount.

coverage Services or benefits provided through a health insurance plan.

delivery system An organized array of service providers coordinated to deliver a set package of services.

dual diagnosis Diagnosis with more than one disorder; usually used to refer to a combination of mental health and substance abuse problems, but the term can also refer to individuals who have a behavioral health diagnosis as well as a medical diagnosis or disability.

dually eligible Typically, those individuals who qualify for Medicaid and Medicare on the basis of age (65 for Medicare) and income threshold (usually 133 percent of FPL for Medicaid). This classification was not separated into its own population category in the report (see Section I), but many programs list the dually eligible as a group covered.

enrolled population The entire group of persons covered by a particular health plan; defined in terms of specific lives covered. Persons enrolled are referred to as enrollees.

exclusion model A model in which States adopt a managed care program for physical health but exclude behavioral health services and keep them in the fee-for-service system.

expanded medicaid Some States may choose to expand their Medicaid eligibility threshold in order to cover more individuals under their Medicaid program. For example, a typical income eligibility threshold might be 133 percent of FPL, but the State may choose to expand Medicaid coverage to include those individuals with incomes up to 300 percent of FPL.

expanded women and children States may choose to cover additional groups under their Medicaid programs, usually additional children and pregnant women whose medical expenses reduce their income to the State's ceiling to qualify as medically needy. Examples of these groups include infants whose family income is up to 185 percent of FPL, pregnant women with incomes up to 185 percent of FPL, and children under age 21 (primarily 18- to 21-year-olds) who meet certain income and resource requirements under AFDC/TANF but are otherwise not eligible for Medicaid.

fee-for-service (FFS) reimbursement A payment approach that pays providers for each unit of service delivered.

full capitation A term often used more broadly than the strict definition of "capitation" to refer to any payment system in which a managed care organization provides and bears the utilization risk for all services included in the benefit package according to a prospectively funded at-risk contracting arrangement tied to covered lives.

full carve-out model A model of care in which States separate mental health and substance abuse services and/or populations from the physical health care program, and include them under a separate behavioral health managed care waiver program.

funding method The mechanism through which a payer (e.g., Medicaid, employer, State Mental Health Authority) pays for the health care of its covered persons.

general assistance Category covering low-income persons who are not eligible for federally funded cash assistance (e.g., AFDC/TANF; SSI) and who receive cash and/or in-kind benefits from the State, county, and/or locality in which the program operates.

health maintenance organization A health care organization that 1) offers an organized system for providing health care within a specific geographic area, 2) provides a set of basic and supplemental health maintenance and treatment services, and 3) provides care to an enrolled group of people.

Institution for Mental Diseases (IMD) The Health Care Financing Administration classification often applied to state hospitals that excludes services for persons age 21 to 64 from coverage under Medicaid; included in original Medicaid legislation to prevent states from shifting the cost of State hospitals to the Federal government.

integrated model Mental health and substance abuse services included in a comprehensive general physical health managed care program.

lead agency An organization that serves as the single clinical and fiscal authority that provides and/or subcontracts for services toward the achievement of a desired outcome.

local mental health authority A local organizational entity (usually with some statutory authority) that centrally maintains administrative, clinical, and fiscal authority for a geographically specific and organized system of behavioral health care.

managed behavioral health care Any of a variety of strategies to control behavioral health (i.e., mental health and substance abuse) costs while ensuring quality care and appropriate utilization. Cost-containment and quality-assurance methods include the formation of preferred provider networks, gatekeeping (or precertification), case management, relapse prevention, retrospective review, claims payment, and others. In many health plans, behavioral health care is separated from other care for the separate management of costs and quality of care.

managed health care An arrangement for health care delivery and financing that is designed to provide appropriate, effective, and efficient health care through organized relationships with providers; includes formal programs for ongoing quality assurance and utilization review, financial incentives for covered members to use the plan's providers, and financial incentives for providers to contain costs.

managed care organization (MCO) An entity, such as an HMO or preferred provider organization, that provides a managed health care plan.

managed fee-for-service (indemnity) product A plan in which the cost of covered services is paid by the insurer after services have been used. Various managed care tools such as precertification, second surgical opinion, and utilization review are used to control inappropriate utilization.

Medicaid A Federal program administered individually by participating State and Territorial governments that share in the program's costs to provide medical benefits to specific groups of low-income and/or categorically eligible persons.

Medicaid managed care demonstration A State-initiated managed health care plan undertaken in accord with a procedural waiver for some or all of a State's Medicaid-eligible persons.

Medicaid waiver Waivers such as the Section 1115 waiver and Section 1915(b) waiver.

medical necessity The determination that a specific health care service is medically appropriate, necessary to meet the person's health needs, consistent with the person's diagnosis, the most cost-effective option, and consistent with clinical standards of care.

multiple funding streams A funding method in which funding flows to a service provider in independent streams from various funding sources.

organized systems of care A coordinated network of provider organizations.

outcomes The results of a specific health care service or benefit package.

outpatient care Health care not requiring a stay in a licensed hospital or nursing home bed.

partial capitation A payment system in which some services included in the benefit package are funded according to an at-risk contracting arrangement and some through fee-for-service or other traditional form of reimbursement.

partial carve-out model A model in which States use an integrated approach for some mental health and/or substance abuse services but place other (and often expanded) mental health services and/or populations under a separate managed care program.

payer The public or private organization responsible for payment for health care expenses.

performance goals The desired level of achievement of standards of care or service. These may be expressed as desired minimum performance levels (thresholds), industry best performance (benchmarks), or the permitted variance from the standard. Performance goals usually are not static but change as performance improves and/or the standard of care is refined.

performance measures Methods or instruments to estimate or monitor the extent to which the actions of a health care practitioner or provider conform to practice guidelines, medical review criteria, or standards of quality.

pooling The process of combining all claims or cost experience for defined populations or types of coverage into one risk pool in order to spread risk or claims liability.

preferred provider organization (PPO) An organization that contracts with specific providers to provide health care services to enrollees, and structures its benefit package to provide incentives for the use of these contracted providers.

prepaid health plan (PHP) A contract between an insurer and a subscriber or group of subscribers whereby the PHP provides a specific set of health benefits in return for a periodic premium. PHPs are usually clinics or large group practices and are typically at risk for ambulatory services but not for a comprehensive set of benefits.

primary care case management (PCCM) A managed care option, allowed under section 1915(b) of the Social Security Act, in which each participant is assigned to a single primary care provider who must authorize most other services before the provider can be reimbursed by Medicaid.

primary care physician (PCP) The physician responsible for coordinating and managing a member's health care needs, including hospitalization or referral to a specialist.

privatization The effort to shift traditional functions formerly carried out by governmental agencies to private sector organizations, usually under the rubric of managed care; most often involves management and financing functions.

provider Person or organization providing health care services.

public/private partnership A joint venture between public and private organizations that attempts to combine private sector expertise in managed care models and techniques with public sector expertise in models of care for seriously impaired or low-income populations.

quality assessment Measurement of the technical and interpersonal aspects of health care and the outcomes of that care.

quality assurance A systematic and objective approach to improving the quality and appropriateness of medical care and other services; includes a formal set of activities to review, assess, and monitor care and to ensure that identified problems are addressed appropriately.

risk The difference between projected and actual expenses. Risk strategies are approaches taken to decide who will assume responsibility for paying for, or otherwise provide, a specified set of services based upon unpredictable need for a particular set of services. Risk strategies require managed care entities or providers to assume all or some portion of the financial risks of treatment.

risk sharing The process of establishing a financial arrangement that distributes the financial risk of providing care among providers, payers, and those who use the services.

risk shift The transfer of risk for the costs of services from one responsible party to another, either through explicit contract or de facto practice.

Section 1115 research and demonstration A statutory provision that allows a State to operate its system of care for Medicaid enrollees in a manner different from that prescribed by the Health Care Financing Administration in an attempt to demonstrate the efficacy and cost-effectiveness of the alternative delivery system through research and evaluation. It is sometimes referred to as a "comprehensive" or "super waiver," and usually applies to a large number of Medicaid eligibles and a comprehensive range of services.

section 1915(b) A statutory provision that allows a State to partially limit the choice of providers for Medicaid enrollees. For example, under the waiver a State can limit enrollees from disenrolling from an HMO more than once a year. Even though this type of waiver is narrower than the 1115 waivers, it still allows States to experiment with managed care systems.

service area The geographic area covered by a managed care plan, where direct services are provided.

SSI or ABD Federal Supplemental Security Income (SSI) (sometimes referred to as the program that serves "aged, blind, and disabled" (ABD) individuals) is based on age, disability, and income. Adults under age 65 and children may qualify for SSI by virtue of physical disability, blindness, mental illness, mental retardation, or developmental disability.

stakeholders Groups of persons with a vested interest in the design and functioning of a service or product. For public behavioral health care, stakeholders include consumers, family members of consumers, service providers, legislators, State mental health and substance abuse agencies, and managed care organizations.

state alcohol and drug abuse authority or agency A State government agency charged with administering and funding the State's substance abuse health services.

state mental health authority or agency A State government agency charged with administering and funding the State's public mental health services.

stop-loss (risk control insurance) Insuring with a third party against a risk that the plan cannot financially manage. For example, a health plan can self-insure hospitalization costs, or it can insure hospitalization costs with one or more insurance carriers.

subcapitation An arrangement whereby a capitated health plan pays its contracted providers on a capitated basis.

subcontract The act of delegating through a second contract with a third party contractual obligations between two original parties.

unified funding stream A funding arrangement in which funding flows to a service provider in a single, unified stream consolidated by the payer from multiple funding sources.

utilization The extent to which eligible individuals use a program or receive a service or group of services over a specified period of time.

utilization management A system of procedures designed to ensure that the services provided to a specific client at a given time are cost-effective, appropriate, and least restrictive.

utilization review (UR) A retrospective analysis of the patterns of service usage undertaken to determine the means for optimizing the value of services provided (i.e., minimize cost and maximize effectiveness/appropriateness).

wraparound coverage A continuum of benefits organized around an individual enrollee's treatment needs.

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Appendix C: Behavioral Health Service Definitions

inpatient 24-hour inpatient mental health and/or substance abuse services that provide medical intervention for mental health and substance abuse needs for the purpose of stabilizing acute psychiatric and substance abuse conditions.

IMD Inpatient services provided in an Institution for Mental Diseases.

crisis Emergency, crisis intervention, or crisis stabilization services that provide short-term psychiatric treatment in structured community-based therapeutic environments as an alternative to hospitalization.

mental health residential 24-hour residential treatment—a community-based facility that offers 24-hour residential care as well as treatment and rehabilitation, short-term crisis stabilization, or long-term rehabilitation. One example is therapeutic group living: therapeutically planned group living delivered on a 24-hour basis for enrollees. A step down from inpatient or an alternative to hospitalization.

mental health outpatient Mental health services (e.g., individual, family, or group therapy) provided in an ambulatory care setting such as a mental health clinic, hospital outpatient department, or community health center.

mental health rehabilitation Services to assist individuals to develop or improve task- and role-related skills and social and environmental supports needed to perform as successfully and independently as possible at home, school, and work; and in the family, socialization, recreation, and other community-living roles and environments of their choice.

mental health support Services to promote the ability of enrollees to live as safely and independently as possible in community settings; includes the provision for linking to an array of people, places, activities, and services that are designed to assist enrollees and, when requested by the enrollee, family members and/or significant others in their continuing need to meet the challenges of mental illness and recovery.

outpatient substance abuse Nonresidential ambulatory services provided for the treatment of drug or alcohol dependence, without the use of pharmacotherapies. This includes intensive outpatient services (all-day care for several days) as well as traditional counseling (1 or a few hours per day, usually weekly or biweekly).

detoxification Hospital-based, residential, and ambulatory programs, typically of very short duration (e.g., 3 to 14 days), that provide support services and/or medical assistance during withdrawal from alcohol or drug dependence. Detoxification programs are not treatment programs per se, but may either be connected to treatment programs or provide referrals to treatment. Detoxification services may be provided in standard acute-care beds or in specialty detoxification units.

opiate treatment Treatment programs, usually outpatient, that are licensed by the Food and Drug Administration and the Drug Enforcement Agency to administer either methadone or Levo-Alpha-Acetyl Methadol (LAAM) as pharmacotherapy adjuncts to traditional rehabilitation services for opiate dependence. (LAAM is a longer-acting version of methadone.) Opiate treatment programs typically provide services lasting from several weeks to many years.

residential substance abuse treatment Non-hospital-based 24-hour care programs. These range from short-term chemical dependency programs (lasting typically less than a month), to longer-term residential settings (usually 3 to 6 months), to long-term residential programs, including therapeutic communities (lasting typically between 6 and 18 months). These programs also include specialty residential treatment settings for women and their children.

These service definitions will be adopted by the Health Care Financing Administration in future annual State Medicaid Managed Care Surveys (National Summary of State Medicaid Managed Care Programs). The definitions were developed by the SAMHSA Managed Care Tracking System.